# EXHIBIT G

**UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF GEORGIA**
**ATLANTA DIVISION**

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| **UNITED STATES OF AMERICA,** | ) | |
| | ) | |
| **Plaintiff,** | ) | |
| | ) | |
| **v.** | ) | **Civil Action No. 1:16-cv-03088-ELR** |
| | ) | |
| **STATE OF GEORGIA,** | ) | |
| | ) | |
| **Defendant.** | ) | |
| | ) | |

**DECLARATION AND EXPERT DISCLOSURE OF DR. ROBERT F. PUTNAM**

I, Robert F. Putnam, declare, in compliance with Fed. R. Civ. P. 26(a)(2)(B), as follows:

1. I have been retained, as an employee of the May Institute, to present expert testimony in this matter on behalf of the United States. My attached report contains a complete statement of all opinions to be expressed and the basis and reasons for them.

2. My report describes the facts, data, and other information I considered in forming my opinions.

3. My report includes charts and graphs that may be used as a summary of or support for my opinions.

4. My attached *curriculum vitae* states my qualifications and lists all publications I have authored within the past ten years.

5. I provide my testimony pursuant to a contract between the United States Department of Justice and the May Institute. The May Institute has charged $300 per hour for my time and $180 per hour for data analysts who assisted me in the preparation of my report.

6. I have not testified as an expert at trial, or by deposition, within the preceding four years.

7. I declare, pursuant to 28 U.S.C. §1746, under penalty of perjury and under the laws of the United States of America that the foregoing is true and correct.

Executed this 16 day of June 2023,

Dr. Robert F. Putnam

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

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| UNITED STATES OF AMERICA,<br><br>PLAINTIFF,<br><br>*v.*<br><br>STATE OF GEORGIA,<br><br>DEFENDANT. | Civil Action No.<br>1:16-cv-03088-ELR |

**EXPERT REPORT OF ROBERT PUTNAM, PH.D., L.P., LABA, BCBA-D**

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## SUMMARY OF OPINION

The vast majority of students with behavior-related disabilities, including students at serious risk of restrictive educational placement, can be served effectively in general education schools within their communities. The therapeutic services and supports that help students remain in more integrated educational settings are well established, as are the frameworks for implementing and sustaining those services at the system level.

The State of Georgia has implemented key therapeutic services and supports that could help to divert students from unnecessary placement in the Georgia Network for Educational and Therapeutic Support (GNETS) Program, a statewide system of segregated educational settings. But Georgia currently does not provide those services consistently and in sufficient quantities or intensity to many students who need them.

Georgia can decrease its reliance on the GNETS Program by making reasonable changes to its service system, including expanding existing therapeutic services and supports, improving coordination and data collection across the State's child-serving agencies and community partners, and providing robust training and technical assistance.

## PART I: EXPERT QUALIFICATIONS

Over my 50-year career, I have worked extensively with and on behalf of children and adults with behavior-related disabilities at high risk of placement in restrictive educational or therapeutic settings. I completed my Ph.D. in Special Education at Boston College in 1985 and maintain active licenses as a psychologist, behavior analyst and a board-certified behavior analyst-doctoral. My curriculum vitae is attached to this report and contains a list of the publications I have authored during the last 30 years.

I began my career with roles at a large state institution for individuals with Intellectual and Developmental Disabilities (IDD) and a school for students with IDD, working in both places to develop behavioral support plans to address high-risk behavior. For the next 12 years, I worked as a licensed psychologist and behavioral services program director at a Community Mental Health Center in Massachusetts. In addition to developing and managing residential and day service programs for adults with IDD and challenging behaviors, I created a statewide mobile crisis intervention program targeting individuals with co-occurring IDD and mental illness who were at high risk of segregated placement. This effort included implementing a care coordination framework to ensure continuity of services across the continuum. To my knowledge, it was among the first integrated systems of care for this population in the United States.

During the same period, I developed a private practice providing direct care services, including cognitive behavior therapy, to individuals with a wide range of emotional and behavioral disorders. That work morphed into a new role in which I provided behavioral consultation to a large school district in Massachusetts concerning students at risk of segregated educational placements, whether in self-contained classrooms in a general education setting or a separate facility. With my guidance, the district was able to achieve some of the highest rates of inclusionary services among the 15 largest school districts in the state, serving more children in inclusive placements in general education schools and spending less per capita on restrictive placements.[1] This project has served as a state and national model for preventing more restrictive educational placements for students with severe behavior disabilities.

[1] Robert Putnam et al., *Cost-Efficacy Analysis of Out-Of-District Special Education Placements: An Evaluative Measure of Behavior Support Intervention in Public Schools* (2002).

For approximately 30 years, I have worked at the May Institute ("the Institute"), a large nonprofit private behavior health organization focusing on data- and evidence-based services. In my first role at the Institute as director of mental health services, I managed efforts to implement data- and evidence-based psychiatric services at the child and adolescent inpatient units located at McLean Hospital and Somerville Hospital. I also managed day treatment services for individuals with co-occurring IDD and mental illness, as well as the Institute's community and outpatient mental health services. For the past 25 years, my primary role at the Institute has been providing behavioral consultation services to school districts across the country. My consultation entails, among other things, supporting districts in their implementation of data- and evidence-based inclusionary services and supports that prevent more restrictive placements for students with severe behavior disabilities.

I am a national authority on integrating school- and community-based mental health services in a multi-tiered framework called the Interconnected Systems Framework. In addition to managing the statewide Multi-Tiered Systems of Support (MTSS) and Positive Behavioral Interventions and Supports (PBIS) initiative for Massachusetts, I started and co-chair a national workgroup at the Association for Positive Behavior Support that focuses on integrating PBIS and mental health services. I serve as one of ten national partners of the National Technical Assistance Center for PBIS, as well as a leader of the Center's mental health workgroup and the chair of its Tier III workgroup.

I have authored or co-authored numerous peer-reviewed articles on the topics of MTSS, PBIS, and supporting students with severe behavior-related disabilities in integrated educational settings. I also regularly present and teach on those topics, including at the American

Association for Positive Behavior Supports. In 2018, I was elected President of the Massachusetts Association of Applied Behavioral Analysis.

Compensation for this report is provided pursuant to a contract between the United States Department of Justice and the May Institute. The Institute bills my time at a rate of $300 per hour, in addition to travel costs and other incidental expenses. I have been assisted by Institute data analysts who are working at my direction; the Institute bills their time at a rate of $180 per hour. The Institute's compensation does not depend on the outcome of this case. I have not testified as an expert in a deposition or at trial in the last four years.

## PART II: METHODOLOGY

I was asked to assess whether Georgia can reasonably modify its behavioral health system to allow students with behavior-related disabilities to receive services in more integrated settings appropriate to their needs. In conducting this assessment, I:

- reviewed documents that describe the State's existing infrastructure,
- observed depositions of State officials and Community Service Board (CSB) staff,
- conducted site visits to schools in Georgia, and
- considered scholarly research on behavioral health services.

I reviewed materials that explain how the State serves students with behavior-related disabilities. In particular, I reviewed Georgia's statutes, regulations, and standards that govern the State's Department of Education (GaDOE), the Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Department of Community Health (DCH). I reviewed documents that describe the Georgia Network for Educational and Therapeutic Support Program (GNETS); DBHDD's Georgia Apex Program (Apex) and DBHDD's Apex data analysis contractor, the Georgia State University Center of Excellence ("COE"); GaDOE's Positive

Behavioral Interventions and Supports (PBIS) Program; documents that explain how CSBs and other entities provide services to students with behavior-related disabilities; and communications sent to or received by State agency officials. I also analyzed data publicly available on Georgia state agencies' websites and data produced by the State in this litigation. That data contained information about GNETS, Medicaid-reimbursable services, Apex services, PBIS implementation, the COE, and other information related to behavioral health services.

I observed or read transcripts of depositions, including the testimony of current and former GaDOE staff responsible for GNETS and PBIS, and current and former DBHDD and service provider staff responsible for Apex and other behavioral health services.

Between May 2022 and March 2023, I conducted site visits to some 27 schools. These included general education schools, a stand-alone GNETS center, and GNETS classrooms housed in general education schools. These visits involved a tour of each school, classroom observations, as well as, for school visits beginning in October 2022, interviews of school staff and school district administrators. State administrators, GNETS staff, and CSB staff in attendance sometimes contributed to these discussions. To select schools to visit, I considered factors such as: the rate at which the school and district were listed as the home school and district for GNETS students, the student enrollment in the school, whether the school participated in Apex and/or PBIS, and the school's geographic location. During each visit, I inspected at least one elementary, middle, and high school. *See* Appendix C for more detailed information about the site visits.

Finally, my decades of expertise in behavioral psychology, applied behavior analysis, special education, and behavior interventions inform my opinions. I based my opinions on

research and scholarly papers, issue briefs, accepted professional standards, and my 50 years of experience serving students with behavioral health disabilities.

*See* Appendix B for the complete list of the materials that I considered.

## PART III: STANDARDS OF CARE FOR SERVING STUDENTS WITH BEHAVIOR-RELATED DISABILITIES

There is broad scientific consensus that students with behavior-related disabilities who receive timely, appropriate services can avoid restrictive educational placements and be served in more integrated educational settings within their communities. The harms of segregations for these children are likewise firmly established.

To work as intended, the therapeutic services described below must be provided by trained and qualified professionals, with sufficient intensity, and with fidelity to recognized standards. Especially for students at serious risk of restrictive educational placement, early identification of their behavioral needs is critical.

### I. Core Services for Supporting Students with Behavior-Related Disabilities in More Integrated Settings and Elements of Effective Service Delivery

Researchers, service providers, and educators have coalesced around a core set of interventions—including Functional Behavior Assessments and Behavioral Intervention Plans, Wraparound Services, Family and Community Support, and Individual and Group Therapy—that are effective in supporting students with behavior-related disabilities in more integrated settings. These evidence-based supports, among others, when delivered with sufficient intensity and in a timely manner, help students acquire new skills and behaviors to improve their daily functioning and well-being.

### A. Functional Behavior Assessments and Behavior Intervention Plans

A student's needs and behaviors must be well-assessed before a clinician can identify needed services. One validated assessment technique is a Functional Behavior Assessment ("FBA"). Decades of research demonstrate the effectiveness of the use of FBAs and related Behavior Intervention Plans ("BIPs"), which is why they are widespread, accepted, school-based practices used to improve contextually-inappropriate behavior. Such behaviors are one of the leading indicators of risk of restrictive school placements, so the use of FBAs and BIPs helps students remain in general education classes and at their home school.[2]

An FBA is an assessment used to define an individual student's target behavior and determine its context and function (or motivation). Behavior Health Assessments are a useful start to the assessment process but only a start to this process, particularly with students with challenging behaviors. These students should receive diagnostic and psychological assessments to more refine the diagnostic picture to assist in designing interventions. Further, an FBA would specifically operationally define the problem behavior, its context, and its functions as to develop more targeted and refined interventions.

If conducted with fidelity, FBAs provide information necessary for staff to design interventions that successfully modify the context in which such behaviors occur, teach replacement behaviors matched to the function of the original behaviors, and design systems that reinforce the desired and replacement behaviors. A replacement behavior is a more appropriate behavior designed to serve the inappropriate behavior's function in the same context. Such interventions are set out in a student's BIP. Since most challenging behaviors that lead to more restrictive educational placements occur in the classroom, an FBA should be conducted by

[2] *See* U.S. Department of Education, *Functional Behavioral Assessment-based Interventions*, WWC Intervention Report (Dec. 2016) https://ies.ed.gov/ncee/wwc/Docs/InterventionReports/wwc_fba_011017.pdf.

reviewing the student's records, observing the student in the classroom, interviewing educational staff (particularly classroom staff), and collecting data in the classroom.[3] Once the FBA is complete, a professional constructs a BIP based on the hypotheses developed during the FBA.

A BIP should describe the inappropriate behavior(s), identify the context in which it occurs, and propose desired and replacement behavior(s). It should also identify antecedent practices the teacher or classroom staff should utilize to decrease the probability of the student engaging in inappropriate behavior and increase the probability of the desired replacement behavior occurring. The BIP should also specify what teaching strategies should be used to teach the replacement behavior and other social and coping skills. These skills could be taught in the classroom or through individual or group social skills training or therapy provided by mental health staff. In addition, the BIP should suggest reinforcement strategies that will be delivered when the desired and replacement behavior occurs, as well as the appropriate response to inappropriate behavior so as to discourage or prevent it. Finally, the BIP should propose methods of progress monitoring, including data to be collected.

The more complex and intense a problem behavior, the greater the sophistication required to conduct an FBA and resulting BIP. Skilled staff should conduct and develop the FBA and BIP.[4] If an FBA is done inadequately and the BIP is not clearly linked to the FBA, school staff will not understand the student's needs and causes of behaviors, and the behavior will likely

[3] 33 Kari N. Nahgahgwon et al., *Function-Based Planning for Young Children at Risk for Emotional and Behavioral Disorders*. Education and Treatment of Children, 537-559 (4th ed. 2010).

[4] As will be discussed in Part IV, infra, the GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15, acknowledges the importance of the FBA and the BIP. This rule, somewhat confusingly, appears to require either an FBA ***or*** a BIP. It provides that students only be recommended for GNETS services when that recommendation is "based on the existence of all of the following, which will be documented in the student's education record: … 2. A Functional Behavioral Assessment (FBA) and/or Behavior Intervention Plan (BIP) administered within the past year." However, this requirement does not specify that both the FBA and the BIP must be completed by an experienced individual qualified to understand the functions of behavior and to develop an appropriate BIP. Nor does it specify the importance of training the individuals who will implement the BIP.

persist. The clinician must train classroom and other educational staff to implement the BIP with fidelity once the clinician designs it. Thereafter, the clinician and classroom or other educational staff must monitor relevant data to determine whether the BIP needs to be modified or checked for fidelity. Without each component in place, students with significant behavioral needs are likely to experience continued exclusionary discipline and possibly more restrictive placements.[5]

**B. Wraparound Services**

Wraparound, known as Intensive Customized Care Coordination ("IC3") in Georgia, is a community-based approach to providing intensive, individualized support to children and families with complex needs. Wraparound involves convening a team of service providers, family members, and other important people in the child's life to develop and implement an individualized plan of care based on the child's and family's needs and perspective.[6] Children and caregivers receive coaching and skill building, strengths-based planning, and coordination of therapeutic interventions such as Individual Counseling.[7] The goal of Wraparound is to keep children in their communities while addressing their individual needs in a coordinated and collaborative manner across all systems and settings they touch. Georgia requires IC3 providers to coordinate with children receiving IC3 services, their caregivers, or other members of

[5] *See* Daniel M. Maggin et al., *Intensive Interventions for Students With Emotional and Behavioral Disorders: Issues, Theory, and Future Directions*, 24 Journal of Emotional and Behavioral Disorders 127-137 (Hammill Institute Issue No. 3, 2016).
[6] Jonathan R. Olson, et al., *Systematic Review and Meta-analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents*, 60 J. American Academy Child & Adolescent Psychiatry, 1353-1366, (Issue 11, 2021). *See also* FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers 83-84 (January 1, 2023).
[7] Jonathan R. Olson, et al., *Systematic Review and Meta-analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents*, 60 J. American Academy Child & Adolescent Psychiatry, 1353-1366, (Issue 11, 2021). *See also* FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 83 (January 1, 2023).

students' IC3 teams, "an average of three hours" each week with one face-to-face meeting weekly for an average of "12-18 months."[8]

Research shows that Wraparound can lead to improved outcomes for children and families, including improved academic performance, reduced behavioral problems, and increased family satisfaction. Several studies have examined the impact of Wraparound on educational placements for students with challenging behaviors and demonstrated that students who received Wraparound were less likely to experience school disciplinary actions, more likely to remain in general education settings, and less likely to be placed in special education or alternative placements.[9]

### C. Family and Community Supports

Students with challenging behaviors typically exhibit these behaviors across many settings, including at home, in school, and in the community. It is important that families get the support they need, including resource coordination, resiliency planning, and skill support, to respond to students' behaviors in appropriate ways. Support in the community and with families also supports the effectiveness of school-based interventions. Georgia instructs providers of Community Support to contact students "a minimum of twice each month,"[10] and providers of a particular family support service, Intensive Family Intervention, to "offer a minimum of 3 contacts per week with the youth/family."[11]

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[8] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, pages 83-84 (January 1, 2023).
[9] *See* Jonathan R. Olson, et al., *Systematic Review and Meta-analysis: Effectiveness of Wraparound Care Coordination for Children and Adolescents*, 60 J. American Academy Child & Adolescent Psychiatry, 1353-1366, (Issue 11, 2021). Another study examined the impact of Wraparound on students who were already placed in restrictive educational settings, such as special education classrooms or alternative schools. Students who received Wraparound while in these settings were more likely to be successfully transitioned back to less restrictive settings, such as regular education classrooms. Lucille Eber & Rush Osuch, *School-based applications of the Wraparound process: Early results on service provision and student* outcomes. 5 J. Children Family Studies, 83–99 (1996).
[10] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 25 (January 1, 2023).
[11] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 99 (January 1, 2023).

### D. Individual and Group Therapy

Individual and group therapy are therapeutic approaches that aim to address specific mental health concerns, such as anxiety, depression, or behavioral difficulties. In educational settings, individual therapy can be used to help students with behavior-related disabilities learn to regulate their emotions, develop coping skills, and improve social skills. Research shows that individual[12] therapy reduces internalizing and externalizing problem behaviors[13] and that students who have received individual therapy/social skills interventions experience significant improvements in their academic and behavioral outcomes. [14]

### E. Key Elements of Effective Service Delivery

#### 1. Service Intensity and Fidelity

Research demonstrates that to be effective, services must be delivered with sufficient intensity and assessed for fidelity to established standards.[15] In my experience, a student with behavior-related disabilities who is at serious risk of a restrictive educational placement typically would need to receive, at minimum, weekly services that could include Individual or Group Therapy, Wraparound Services, and Community Support.

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[12] It is important to note that individual therapy, like any appropriate intervention, must be tailored to meet the individual needs of each student with EBD. For example, a student who struggles with emotional dysregulation may benefit from cognitive-behavioral therapy, which focuses on changing negative patterns of thinking and behavior, and teaches coping skills. A student who struggles with social skills may benefit from social skills training, which focuses on developing communication, problem-solving, and interpersonal skills.

[13] "Internalizing" and "externalizing" are terms clinicians use to describe "two broad categories of behavioral problems: Whereas internalizing problem (INT) behavior is focused on the own self (e.g., withdrawal, anxiety, depression, emotional problems), externalizing problem behavior (EXT) particularly occurs in interaction with the social environment (e.g., aggression, impulsivity, deviance, hyperactivity)." Amelie Nikstat & Rainer Riemann, *On the etiology of internalizing and externalizing problem behavior: A twin-family study,* National Library of Medicine (Mar 23, 2020) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7089526/#:~:text=Internalizing%20and%20Externalizing%20are%20two,with%20the%20social%20environment%20(e.g.%2C, last accessed 06/12/2023.

[14] Frank Gresham, *Evidence-based social skills interventions for students at risk for EBD*, 36 Remedial and Special Education 100–104 (Issue 2, 2015).

[15] Karen Bierman & Michael Sanders, *Teaching explicit social-emotional skills with contextual supports for students with intensive intervention needs*, 29 J. Emotional Behavioral Disorders 14-23 (Issue 1, 2021).

Assessing services for effectiveness includes monitoring and collecting data about the students' classroom behavior and behavioral health status on regular basis and using that data to determine whether the student is benefitting from any services they receive. Fidelity helps to ensure that the services are working as intended—specifically, by improving the students' educational and behavioral outcomes in maximally integrated settings. Fidelity in this context means that the services are delivered as described in the BIP or as described in the evidence-based protocol or manual. If the data show no progress, providers should re-assess their service delivery for fidelity to established standards, modify the services provided, or replace them with different services that might yield better results.

**2. Early Identification**

Research demonstrates that while some schools offer some mental health services, many students who need these services do not receive them. Even if a child is identified as needing additional supports, teachers may lack training and resources to provide evidence-based social skills interventions.[16] In addition, schools may face competing demands, such as academic achievement or standardized testing, that may take priority over social-emotional development and mental health.

To support students in integrated settings and avoid educational disruptions that may lead to segregated placements, students with intensive behavioral needs must be identified and connected to services. The earlier this occurs in a student's education, the sooner they can be matched with the appropriate supports and services necessary for them to succeed. Research

[16] *See, e.g.*, Wendy Reinke, et al., *Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers*, 26 School Psychology Quarterly, 1–13 (2011); Tracey Silveira-Zaldivara & Heidi Curtis, *"I'm Not Trained for This!" And Other Barriers to Evidence-Based Social Skills Interventions for Elementary Students with High Functioning Autism in Inclusion*, 12 International Electronic Journal of Elementary Education, 53-66 (2019).

shows that the early identification of students in need of services makes a big difference in their educational trajectory and whether they will need more restrictive and intensive services.[17] Supporting children's social, emotional, and behavioral development at early ages may mitigate the need for long-term services and supports.[18]

## II. The Harms of Segregation

The unnecessary segregation of students with disabilities leads to serious problems that are well documented in the research literature. Students who are removed from the general education setting for significant periods have less exposure to the general education academic curriculum and few interactions with students without disabilities. Students in alternative settings also experience extraordinarily high rates of lost instruction.[19] In segregated settings, staff often group students removed from the general education setting with students who are less academically or socially competent than the students they would have encountered prior to being removed; such restrictive placements reduce the pace of a student's academic and social skill acquisition.[20] In addition, being placed in a segregated setting increases the likelihood that students in that setting will be educated alongside peers with challenging behaviors, which exacerbates behavior problems via the processes of peer modeling and selective reinforcement, known as the contagion effect.[21]

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[17] *See* Hirokazu Yoshikawa et al., *Investing in our future: The evidence base on preschool education*, Society for Research in Child Development (2013); Leah J. Hunter et al., *Assessing Noncognitive Aspects of School Readiness: The Predictive Validity of Brief Teacher Rating Scales of Social–Emotional Competence and Approaches to Learning*, 29 Early Education and Development 1081-1094 (2018).

[18] *See* Hirokazu Yoshikawa et al., *Investing in our future: The evidence base on preschool education*, Society for Research in Child Development (2013).

[19] Daniel J. Losen & Paul Martinez, *Lost Opportunities*, The Center for Civil Rights Remedies (2020) https://civilrightsproject.ucla.edu/research/k-12-education/school-discipline/lost-opportunities-how-disparate-school-discipline-continues-to-drive-differences-in-the-opportunity-to-learn/Lost-Opportunities-REPORT-v17.pdf.

[20] Julie Causton-Theoharis et al., *Does Self-Contained Special Education Deliver on Its Promises? A Critical Inquiry into Research and Practice,* 24 Journal of Special Education Leadership 61-78 (2011).

[21] Thomas J. Dishion, & Jessica M. Tipsord, *Peer Contagion in Child and Adolescent Social and Emotional Development*, 62 Annual Rev. Psychology (2010).

My personal observations from over 30 years of working with hundreds of schools to reduce segregated placements of students with behavior-related disabilities match what the research documents. I have repeatedly seen students achieve better social-emotional and behavioral outcomes and academic performance when they are placed in inclusive settings. Students with emotional and behavioral disabilities thrive in general education settings when provided with appropriate supports. Indeed, the consensus among professionals who work with these students—including myself—is that in most cases they can be served in integrated settings in their home schools and attend class with general education students, provided they receive the proper supports.

## III. Factors that Put Students with Behavior-Related Disabilities at Higher Risk of Restrictive Placement

Students at the highest risk of placement in segregated educational settings typically are those whose behaviors include aggression, violence, severe defiance and disruption, property damage, or elopement (running away from a classroom or building). Students with these behaviors and diagnoses are often categorized as having an Emotional and Behavioral Disorder("EBD"). From a diagnostic perspective,[22] these behaviors are often associated with and derive from the following diagnoses: Conduct Disorder (CD), Intermittent Explosive Disorder (IED), Oppositional Defiant Disorder (ODD), Attention Deficit Hyperactivity Disorder (ADHD), or Autism Spectrum Disorder (ASD).

In elementary and secondary school, when teachers do not have sufficient support or training they often use exclusionary discipline such as office disciplinary referrals ("ODRs"), and in- and out-of-school suspensions ("ISS" and "OSS") to remove such students from the

[22] *See* American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (*DSM-5*-TR).

classroom. The behaviors these students exhibit can also trigger consideration for more restrictive placements. Thus, these behaviors, which stem from the students' disabilities, place those students at risk of significant loss of learning opportunities and transfers from their home school to segregated classrooms and schools.

"Often, student misbehavior is attributed exclusively to students themselves, but researchers know the same student can behave very differently in different classrooms."[23] When teachers are not equipped to support students in the classroom, do not have access to sufficient supportive services, and have less support from the administration, they are more likely to resort to exclusionary discipline and take the view that a more restrictive placement is appropriate. Classroom disruptions tend to increase or decrease with a teacher's skill in providing engaging instruction and in managing the classroom[24]—areas many teachers say they would like help improving.[25]

Classroom teachers refer students engaging in inappropriate behaviors to administrators, who also frequently lack adequate preparation and training. Research demonstrates the lack of preparation and training in appropriate interventions and inclusive values.[26] Principals, who often oversee the suspension and expulsion of students, are frequently the "major driver" in the frequency and severity of school discipline.[27] Research demonstrates that, tracking principals

[23] Daniel J. Losen, *Discipline Policies, Successful Schools, and Racial Justice*, National Education Policy Center (Oct. 2011) https://nepc.colorado.edu/sites/default/files/NEPC-SchoolDiscipline.pdf.
[24] Daniel J. Losen, *Discipline Policies, Successful Schools, and Racial Justice*, National Education Policy Center (Oct. 2011) https://nepc.colorado.edu/sites/default/files/NEPC-SchoolDiscipline.pdf.
[25] Regina M. Oliver & Daniel J. Reschly , Effective Classroom Management: Teacher Preparation and Professional Development. *TQ Connection Issue Paper*, National Comprehensive Center for Teacher Quality (2007).
[26] Denise A. Soares, et al., Practice-to-Research: Responding to the Complexities of Inclusion for Students with Emotional and Behavioral Disorders with Recommendations for Schools, 106 NASSP Bulletin 77–108 (May 9, 2022).
[27] Andrew *Bacher-Hicks* et al., *Proving the School-to-Prison Pipeline: Stricter middle schools raise the risk of adult arrest.* 21 Education Next *52-57* (2021).

from one school to another, principals who doled out high numbers of suspensions and expulsions in one school would do the same at the next.[28]

## PART IV: FRAMEWORKS FOR IMPLEMENTING INCLUSIVE SERVICES EFFECTIVELY

Above, I discuss the individual *services and supports* that research demonstrates help students with behavior-related disabilities avoid restrictive educational placements and remain in more integrated educational settings within their communities. In this Section, I describe established frameworks for implementing those services and supports effectively across systems of care: (1) Multi-Tier Systems of Support ("MTSS"), such as Positive Behavioral Interventions and Supports ("PBIS"), which have been shown to be effective for internal coordination among school staff; and (2) the Interconnected Systems Framework ("ISF"), which should build upon systems like PBIS to ensure collaboration between agencies and community partners.

### I. Multi-Tiered Systems of Support and Positive Behavioral Interventions and Supports

MTSS is a data-based decision-making framework that uses multiple tiers with increasing intensity to provide evidence-based supports to students. PBIS is a well-developed MTSS model used in schools throughout the United States to help students increase their social, emotional, and behavioral skills and to decrease inappropriate behaviors.

A fully functioning PBIS framework utilizes three tiers of increasing intensity to provide students with evidence-based supports that are matched specifically to students' needs. Each tier of services builds upon the one before it with more individualization and intensity. Tier I is a universal level, specifying the supports provided to all students across the whole school and in each classroom; Tier II is more targeted and intensive than Tier I and generally applies to only a

[28] Andrew *Bacher-Hicks* et al., *Proving the School-to-Prison Pipeline: Stricter middle schools raise the risk of adult arrest.* 21 Education Next *52-57* (2021).

subset of all students; and Tier III offers the most individualized and intensive supports and services, generally to a very small subset of students with the highest needs, typically 3 to 5% of the population.

Tier I, when implemented with fidelity, has been shown to reduce the number of students who need Tier II and Tier III supports, thereby freeing mental health and behavior support staff to work with students who require more intensive supports. PBIS Tier I interventions include a school-wide behavior support plan that applies to every student in the school and may include other evidenced-based universal interventions. Tier I interventions should also include evidence-based classroom practices such as appropriate praise-to-behavior correction ratios.[29] Tier II interventions are intended for students who are not responsive solely to Tier I interventions and may be at serious risk of needing more intensive, individualized services available at Tier III. Those Tier II interventions include the implementation of standardized protocols such as "Check In Check Out,"[30] group therapy, or small group social skills interventions. Tier III includes many of the evidence-based supports and services described above, including providing students a BIP

[29] One of the most crucial classroom management practices is the ratio of praise statements to error correction statements. Praise statements are positive statements, overt gestures, or actions presented contingent upon appropriate academic or non-academic behaviors demonstrated by an individual or the class. Examples might be "excellent work," "good job," pat on the back, high five, star placed on the student's behavior chart.
Error corrections might be statements or gestures that are presented contingent on inappropriate student behaviors directed at individual students, groups, or the class. These may include prompts, redirects, reprimands, threats, or punishments. One form of error correction might be if the statement contains information about how one SHOULD be behaving (i.e., states the expected behavior. For example, "Everyone should be working silently on their math," "John, you should be in your seat reading instead of walking around," pointing toward a student's seat. On the other hand, other error corrections might be statements that do NOT include information about how one should behave. For example, "Stop calling out," "If you continue to get out of your seat, you will go to the office." *See* Kade R. Downs, et al., *Teacher Praise and Reprimands: The Differential Response of Students at Risk of Emotional and Behavioral Disorders*, 21 Journal of Positive Behavior Interventions 135-147 (2019); Paul Caldarella, et al., *Teacher Praise-to-Reprimand Ratios: Behavioral Response of Students at Risk for EBD Compared with Typically Developing Peers*, 42 Education and Treatment of Children 447-468 (2019).

[30] Check In Check Out (CICO) is a school-based intervention designed to improve behavior and academic outcomes for students who are at risk for behavioral difficulties. The CICO program is a tier II intervention, meaning that it is typically used with students who require more support than is available through universal or tier I interventions but who do not require the intensity of support provided by tier III interventions. Research has demonstrated that the CICO program can be effective in improving behavior and academic outcomes for students.

based on an FBA, individual social skills intervention or therapy, and Wraparound services. The three tiers of services form a continuum and build on each other to function effectively.[31]

A cornerstone of the PBIS framework is its reliance on data at each tier. Typically, such data includes tracking office disciplinary referrals (ODRs), suspensions, attendance, grades, and other factors, often through data programs like the School-Wide Intervention System (SWIS).[32] The data is used to identify the tier of services individual students require and what services they need within their identified tier. Data is also used to track the efficacy of PBIS implementation. If the PBIS framework is being implemented with fidelity, you would expect ODRs, suspensions, and absences to decrease and grades to increase. If a school is not using data to determine the tier of support students require and to track the efficacy of the supports provided, then it is not implementing PBIS with fidelity.

## II. Interconnected Systems Framework

The services provided across the various tiers of an MTSS can be delivered by school- or community-employed staff and are most effective in an integrated and aligned framework like the ISF. ISF refers to a strategic plan that synergizes the efforts of different subsystems, such as mental health and behavior supports, to provide holistic care for students. Instead of subsystems existing in silos, through the ISF they are thought of as parts of a larger, single system that delivers a continuum of supports based on need. ISF builds upon PBIS and MTSS by integrating mental health, community, school, and family partners through a single system of support.[33] In

[31] Kent McIntosh & Steve Goodman, *Integrated* Multi-Tiered Systems of Support *Blending RTI and PBIS*, Guilford Press (Mar. 15, 2016); Michael Petrasek, et al., *Enhancing motivation and engagement within a PBIS framework*, 25 Improving Schools 37–51 (2022).
[32] SWIS is an electronic application for the tracking of exclusionary discipline such as ODRs and suspensions. It was developed by the National Technical Assistance for Positive Interventions and Supports funded by the U.S. Department of Education, Office of Special Programs and promoted by the GaDOE through its PBIS initiative.
[33] Barrett S. Eber, et al., *Fact Sheet-Interconnected Systems Framework 101: An Introduction*, (2019) https://www.pbis.org/resource/fact-sheet-interconnected-systems-framework-101-an-introduction.

the context of this case, one might think of state agencies like GaDOE and DBHDD as sub-systems and ISF as a framework that helps ensure GaDOE and DBHDD function as part of a single system serving students with behavior-related disabilities.

In practice, ISF utilizes the data-driven aspects of PBIS to connect students with individualized services according to the Tier of interventions they require, both in school and in the community. Research demonstrates that ISF schools deliver more Tier II and Tier III interventions to a greater proportion of students than other schools.[34]

The benefits of ISF are plentiful and can have long-term positive effects on students. There is a dramatic difference in the provision of interventions by community mental health clinicians in ISF schools. ISF schools achieve more reductions in ODRs, ISS, and OSS compared to schools that do not implement ISF.[35] ISF has also been found to benefit student and teacher perceptions of school climate, increase engagement, and increase teacher effectiveness. This underscores the critical importance of integrating community mental health clinicians into MTSS teams so they can participate in data sharing and intervention planning.

Students in need of more significant supports typically have challenges in their schools, with their families, and in their communities. Coordination among schools, mental health providers, community providers, and other affiliated entities, as part of an ISF, is therefore crucial for identifying students in need of services and for developing a full understanding of the student's needs, because their behaviors and needs may present differently across settings. Sharing data on students with aggression, severe disruptive and defiant behaviors, self-harm, or

[34] Mark D. Weist, et al., *A randomized controlled trial on the interconnected systems framework for school mental health and PBIS: Focus on proximal variables and school discipline*, 94 J. School Psychology 49-65 (2022).
[35] Mark D. Weist, et al., *A randomized controlled trial on the interconnected systems framework for school mental health and PBIS: Focus on proximal variables and school discipline*, 94 J. School Psychology 49-65 (2022).

elopement can facilitate prompt identification of and access to evidence-based practices matched to their needs. The use of data-based decision-making across service providers is also important.

When a state's service systems are not provided through an interconnected framework like ISF, students with behavioral health needs can fall through the cracks. Early identification is hindered if different providers operate in isolation and are unable to share resources and observations. A child may exhibit symptoms that demonstrate the need for assessment in one environment but not another. This could lead to the child not being assessed for the supports and services they need. Other children may receive services both at school and in the community and would greatly benefit from school- and community-based providers being aware of the child's individual needs and implementing similar behavior interventions across environments.

## PART V: GEORGIA'S SYSTEM OF CARE FOR STUDENTS WITH BEHAVIOR-RELATED DISABILITIES

Georgia has endorsed the central principles of the Interconnected Systems Framework (ISF), committing itself to building a comprehensive System of Care (SoC)[36] for serving students (and all children) with behavior-related disabilities in community settings. But my review of documents, data, and testimony obtained in this matter revealed that key components of Georgia's System of Care—including the GNETS Program, the Apex Program, the PBIS Program, and Project AWARE, all discussed in more detail below—are not effectively addressing the behavioral health needs of its students in general education settings. Moreover,

[36] As defined by Georgia, an interconnected SoC framework involves "a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families [that is] organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them function better at home, in school, in the community, and throughout life." Georgia System of Care Plan 2020, page 7, Exhibit 947, Monica Johnson Deposition, March 2, 2023.

the State's efforts to improve service access and enhance service coordination by implementing its System of Care Plan fall far short of the very goals that Georgia has set for itself.

## I. Roles and Responsibilities of Georgia's State Agencies

Georgia funds and administers a range of services and programs for students with behavior-related disabilities. Responsibility for administering those services and programs is divided among several State agencies, most notably the Georgia Department of Behavioral Health and Developmental Disabilities ("DBHDD"), the Georgia Department of Education ("GaDOE"), and the Georgia Department of Community Health (DCH). DBHDD contracts with provider organizations, such as Community Service Boards,[37] across the state to deliver core and specialty behavioral health services as defined in the agency's Provider Manual, including through DBHDD's school-based behavioral health service delivery program, Apex. Georgia funds these services for students in schools and other community settings principally through its Medicaid and PeachCare for Kids Programs—both administered by DCH—and through state-source grants. DBHDD also contracts with the Georgia State University Center of Excellence ("COE") to provide technical assistance and conduct data collection and analysis relating to, among other things, the Apex Program and Intensive Customized Care Coordination, the State's Wraparound Service.

GaDOE is responsible, through its Office of Whole Child Supports, for assisting districts and schools with their implementation of Positive Behavioral Interventions and Supports

[37] Community Service Boards ("CSBs") are quasi-public entities created by state statute to "become a provider of mental health, developmental disabilities, and addictive diseases services or health, recovery, housing, or other supportive services." GA. CODE ANN. § 37-2-6 (2010). Per the State, CSBs have "the unique capacity and infrastructure, including comprehensive staffing and electronic information systems capability, to provide a seamless continuum of behavioral healthcare, without need for multiple referrals and coordination." Georgia CMHS Block Grant Application FY 2020-2021, Exhibit 10, Dante McKay Deposition, January 27, 2022, pages 33-34.

("PBIS").[38] GaDOE receives federal grants to support the implementation of school-based behavioral health programs, mostly notably through Project AWARE (Advancing Wellness and Resilience in Education). Finally, GaDOE funds and administers GNETS statewide.

## II. The Georgia Network for Educational and Therapeutic Support (GNETS)

The Georgia Network for Educational and Therapeutic Support (GNETS) Program is designed to provide an array of "comprehensive educational and therapeutic support services[,]" in a variety of settings, "to students who exhibit intense social, emotional and/or behavioral challenges."[39] The State specifies that these services should offer "greater intensity and frequency than what is typically delivered in the general education school environment" and be provided by staff with "specialized training in skills designed to deescalate major disruptive behaviors[.]"[40] Regional GNETS programs operate both school-based locations (GNETS classrooms that are co-located at general education settings) and standalone centers (GNETS programs that operate in their own building or space). GNETS services are additionally supposed to be available in general education settings in students' zoned or other public schools,[41] in recognition of the requirement that students with documented special education needs are entitled to receive their education in the least restrictive environment appropriate based on their individual needs.[42] Together, the different GNETS services and placements are intended to create a continuum of services ranging from services provided in general education classrooms, and "by way of a 'pull out' from the general education setting for part of the school day[,]" to partial school-based GNETS placements, full-day school-based GNETS placements,

[38] As described *supra* in Part IV, PBIS is a framework used around the United States to help students increase their social emotional/behavior skills and decrease problem behaviors that interfere with learning and the development of effective social relationships.
[39] GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15(2)(a).
[40] GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15(2)(d).
[41] GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15(4)(c).
[42] GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15(4)(b).

and full-day GNETS center placements.[43] This continuum of services is supposed to "prevent children from requiring . . . more restrictive placement."[44] Through a functioning interconnected SoC, these intensive and therapeutic services could be provided to students in general education settings who are identified as at risk of being placed in more restrictive settings. However, based on my interviews during site visits and my review of testimony and data obtained in the matter, students at serious risk of GNETS placement are not receiving the kinds of therapeutic services – including as required under the GNETS rule – they would need to remain in general educations settings.

## III. Georgia Apex Program

Since 2015, Georgia has sought to increase access to behavioral health services for students in integrated school-based settings through the Georgia Apex Program,[45] a "partnership between community-based behavioral health providers and local school districts."[46] DBHDD oversees Apex, which forms partnerships to embed services in schools spanning pre-kindergarten through 12th grade.[47] The program purports to use "a Multi-Tiered System of Support (MTSS) framework for delivering services to students."[48] Tier I interventions, including a whole school education plan, parent education, and mental health awareness events, "promote universal prevention benefiting the entire school."[49] Tier II "refers to targeted early interventions for at-

[43] GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15(4)(c).
[44] GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15(2)(a).
[45] Dante McKay30(b)(6) deposition, March 9, 2023, page 33.
[46] FY 23 Provider Manual for Community Behavioral Health Providers, page 56 (January 1, 2023).
[47] DBHDD contracts with CSBs and other provider organizations to provide school-based mental health services through the Apex Program, in partnership with local schools and school districts. (Dante McKay 30(b)(6) Deposition, March 9, 2023, pages 33, 44) *See also* https://dbhdd.georgia.gov/georgia-apex-program. The services are partially funded by DBHDD's Child and Adolescents budget. (Dante McKay 30(b)(6) Deposition, March 9, 2023, page 48.)
[48] FY 23 Provider Manual for Community Behavioral Health Providers, page 57 (January 1, 2023).
[49] FY 23 Provider Manual for Community Behavioral Health Providers, page 57 (January 1, 2023); GA05558501 Apex Year 7 Evaluation Slide Deck at GA05558516.

risk students with emerging behavioral health needs," and Tier III "refers to individualized intervention for students identified as living with a behavioral health diagnosis."[50] Tier II and Tier III services include, among others: Behavioral Health Assessment, Community Support, Intensive Customized Care Coordination (IC3), Intensive Family Intervention (IFI), Service Plan Development, and Individual, Group, and Family Counseling.[51] In creating Apex, the State acknowledged that "[r]esearch shows that behavioral and emotional health concerns present significant barriers to learning and academic achievement" but that "mental health interventions are effective and can significantly improve academic performance scores."[52] Georgia chose to follow the "national trend" and "create a more comprehensive approach in meeting the social, emotional, and behavioral needs of students" by "creating a supplementary team of community mental health professionals who are integrated into the school service array."[53]

As part of an interconnected SoC, Apex could be integrated within the State's GNETS Program and PBIS framework, but that rarely occurs in Georgia. Apex explicitly does not provide services in GNETS standalone centers,[54] which are the most restrictive placements in the GNETS continuum and are intended to serve the students most in need of supports and services.[55] DBHDD staff overseeing Apex have little to no knowledge of the GNETS Program, including what if any behavioral health services are available to students in GNETS.[56] While DBHDD and its contractors collect monthly data from Apex providers to assess the program's performance, that reporting does not include any data with respect to the GNETS Program—for

[50] FY 23 Provider Manual for Community Behavioral Health Providers, page 57 (January 1, 2023).
[51] Apex 3.0 FAQs, Exhibit 978, Dante McKay 30(b)(6) Deposition, March 9, 2023.
[52] DBHDD Contract, ABH000004, page 22.
[53] DBHDD Contract, ABH000004, page 22.
[54] Apex 3.0 FAQs, Exhibit 978, Dante McKay 30(b)(6) Deposition, March 9, 2023.
[55] Dr. Jacqueline Neal Deposition, January 19, 2023, pages 67-68.
[56] Dante McKay Deposition, January 27, 2022, pages 49, 74-75, 93-95, 107, 137-139. Layla Fitzgerald Deposition, June 24, 2022, pages 49-51.

example, how many students entered GNETS after receiving Apex services, which services students received, if any, through Apex before entering GNETS, and how many students received Apex services after enrolling in GNETS. This is unsurprising, since the goals of Apex do not include diverting students from GNETS.[57] In addition, the State does not collect any individualized data about the students attending Apex-participating schools.[58] If it collected such data, the State could use it to assess whether the Apex services that students received were effective and to identify other interventions that might help students return to or remain in a general education classroom.

Similarly, I saw little evidence that Georgia leverages its PBIS Program to enhance school-based behavioral health services through Apex. Apex services could be a standard service provided to students in the higher-need PBIS tiers, but it does not appear that this is occurring or that the State is promoting this kind of coordination. When asked about the interaction between PBIS and Apex, former PBIS Program Manager Jason Byars responded: "Apex probably provides services in PBIS schools, but that's probably about it."[59] Even though GaDOE requires schools participating in its PBIS Program to submit discipline referral data[60] and reducing exclusionary discipline is a desired outcome of Apex,[61] DBHDD does not ask Apex service providers to report ODR data for individual students, nor does it appear that DBHDD staff

[57] The overarching goals of Apex are threefold: "1. Increase *access* to mental health services for children and youth; 2. Provide *early detection* of child and adolescent mental health needs, and 3. Strengthen *coordination* between community-based mental health providers and local schools." Apex 3.0 FAQs, Exhibit 978, Dante McKay 30(b)(6) Deposition, March 9, 2023.
[58] Center of Excellence November 2021 Evaluation of the Georgia Apex Program, R0078502, US0101213, Exhibit 787, Lisa Oosterveen Deposition, February 23, 2023.
[59] Jason Byars Deposition, December 2, 2022, page 264.
[60] Jason Byars Deposition, December 2, 2022, pages 171-175.
[61] The program's desired result of Apex is "a reduction of children and youth in Georgia with unmet mental health needs, fewer discipline referrals, and increased academic performance among the children and youth who receive this school-based mental health services to provide early detection of child and adolescent behavioral health needs" and "improve access to mental health services for children and youth." APEX Contract FY2020, ABH000004, US0013064, pages 22-23; Albany Area CSB FY22 Apex Contract, R0078853, Exhibit 784, Lisa Oosterveen Deposition, February 23, 2023.

regularly use that data to assess the Apex Program.[62] If the State reviewed ODR data, it could determine whether certain services helped decrease disruptive behaviors and keep students in their classrooms.[63]

## IV. Positive Behavioral Interventions and Supports

PBIS, as described supra in Part IV, is a data-driven, three-tiered framework developed to increase students' social emotional/behavior skills and decrease problem behaviors that interfere with learning and the development of effective social relationships. Despite Georgia's endorsement of PBIS, it is only in 62% of schools. GaDOE is unaware of any school in Georgia providing a Tier III program, implementation has stalled, there are concerns about fidelity, and other mental health programs and services are not integrated into the PBIS framework.

Since 2007, GaDOE has maintained a dedicated unit of employees who provide support for schools implementing the PBIS framework.[64] This unit was initially created "to address the high rates of exclusionary disciplinary practices used in Georgia K-12 schools, including the disproportionate rates of suspension of students with disabilities."[65] Once the unit was created, it "quickly discovered that in many cases, schools did not have a continuum of behavioral interventions nor did they have established processes of data review or analysis in place to prevent or address problems before they reached a level resulting in exclusionary practices like

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[62] [62] *See* Janel Allen Deposition, January 9, 2023, pages 54-55, 86; Dante McKay Deposition, January 27, 2022, pages 200-202. Center of Excellence November 2021 Evaluation of the Georgia Apex Program, R0078502, US0101213, Exhibit 787, Lisa Oosterveen Deposition, February 23, 2023.
[63] *See* Janel Allen Deposition, January 9, 2023, pages 54-55.
[64] Positive Behavioral Interventions and Supports of Georgia Strategic Plan 2014-2024, Exhibit 970, page 4, Justin Hill 30(b)(6) Deposition, March 6, 2023.
[65] Positive Behavioral Interventions and Supports of Georgia Strategic Plan 2014-2024, Exhibit 970, page 4, Justin Hill 30(b)(6) Deposition, March 6, 2023.

suspension."[66] Despite GaDOE's stated support of the PBIS framework, implementation of the PBIS framework has stalled in many schools across the State.

As of February 2023, 1,419 schools in Georgia (or 62%) had initiated the adoption of the PBIS framework.[67] However, GaDOE defines school adoption of the PBIS framework as any school that has participated in a Tier I training.[68] As of the end of the 2021-2022 school year (SY2022), only about 400 schools (or 17%) had implemented Tier II.[69] As of March 2023, GaDOE was unaware of any school implementing Tier III—the tier for students with the highest needs, and the students who are typically most at risk of a GNETS placement.[70]

GaDOE generally supports school districts and schools with their implementation of PBIS through training[71] and monitoring, which can include tiered fidelity inventory walkthroughs.[72] However, as of March 2023, GaDOE had never provided training to support Georgia schools in their adoption of Tier III,[73] despite GaDOE's formal support of PBIS starting 15 years ago,[74] and its determination in 2017 that it would roll out Tier III training during

[66] Positive Behavioral Interventions and Supports of Georgia Strategic Plan 2014-2024, Exhibit 970, page 4, Justin Hill 30(b)(6) Deposition, March 6, 2023.
[67] PBIS Training Memo, Exhibit 976, Justin Hill 30(b)(6) Deposition, March 6, 2023; Quick Facts on Georgia Education 2021-2022, https://www.gadoe.org/External-Affairs-and-Policy/communications/Pages/Quick-Facts-on-Georgia-Education.aspx.
[68] Justin Hill 30(b)(6) Deposition, March 6, 2023, page 37; PBIS Training Memo, Exhibit 976, Justin Hill 30(b)(6) Deposition, March 6, 2023.
[69] Justin Hill 30(b)(6) Deposition, March 6, 2023, page 37; Quick Facts on Georgia Education 2021-2022, https://www.gadoe.org/External-Affairs-and-Policy/communications/Pages/Quick-Facts-on-Georgia-Education.aspx.
[70] Justin Hill 30(b)(6) Deposition, March 6, 2023, page 37.
[71] Justin Hill 30(b)(6) Deposition, March 6, 2023, page 34; Jason Byars Deposition, December 2, 2022, page 53.
[72] Justin Hill 30(b)(6) Deposition, March 6, 2023, page 92; Jason Byars Deposition, December 2, 2022, pages 171-175, 178.
[73] Justin Hill 30(b)(6) Deposition, March 6, 2023, pages 37-38; Jason Byars Deposition, December 2, 2022, pages 157-158.
[74] Positive Behavioral Interventions and Supports of Georgia Strategic Plan 2014-2024, page 4, Exhibit 970, Justin Hill 30(b)(6) Deposition, March 6, 2023.

SY2021.[75] GaDOE staff have acknowledged that the failure to fulfill this and other important goals is partly due to the lack of resources GaDOE has provided for PBIS support.[76]

Many of the schools GaDOE counts as having the PBIS framework have also stalled in their efforts to implement PBIS with fidelity. GaDOE requires participating schools to submit PBIS data and uses this data annually to rate each schools' PBIS Program as "installing," "emerging," "operational," or "distinguished."[77] "Installing" is the initial stage or category and "distinguished" is the final stage or category, but simply recognizes schools with certain data requirements that have been trained in Tiers I and II.[78] There is no formal expectation from GaDOE that the PBIS schools ranked as distinguished have implemented a Tier III system. Further, there are schools that adopted the PBIS framework years ago that are still categorized as "installing."[79] This is especially concerning because, as GaDOE acknowledges, research shows that if schools fail to develop their tiers within three years, their discipline trends slowly reverse.[80]

My personal observation of 27 Georgia schools also raised concerns regarding the fidelity with which PBIS is being implemented. I observed schools that claimed to have adopted a PBIS framework, yet saw no evidence of a data-driven PBIS framework. I observed schools with very little positive reinforcement, and at least one school that claimed to have a PBIS framework but was only able to point to its use of a PBIS store, which creates a token economy that is not, in

[75] Justin Draft Tiered Timeline Email, GA03425967, Exhibit 971, Justin Hill 30(b)(6) Deposition, March 6, 2023; Justin Hill 30(b)(6) Deposition, March 6, 2023, pages 52-54.
[76] *See* Justin Hill Email, GA03425886, Exhibit 972, Justin Hill 30(b)(6) Deposition, March 6, 2023.
[77] Georgia DOE Positive Behavioral Interventions and Supports (GaPBIS) Levels of School Recognition for 2022-2023 School Year, Exhibit 977, Justin Hill 30(b)(6) Deposition, March 6, 2023.
[78] Georgia DOE Positive Behavioral Interventions and Supports (GaPBIS) Levels of School Recognition for 2022-2023 School Year, Exhibit 977, Justin Hill 30(b)(6) Deposition, March 6, 2023.
[79] Email from Sandra DeMuth to Tammi Clarke, Exhibit 682, Jason Byars Deposition, December 2, 2022.
[80] Justin Hill 30(b)(6) Deposition, March 6, 2023, page 71.

isolation, a complete PBIS framework. No school that I saw had a fully-functioning Tier III system. This is concerning to me because it indicates that the students most in need of services are not receiving evidence-based treatment aligned to their individual needs as part of the PBIS framework. I also observed schools with negative school climates—where there was little affirmation of positive behavior—which is concerning because as DBHDD officials have noted, "negative school climate[s] can be an incubator for behavior issues."[81]

Research demonstrates the importance of integrating clinical professionals into PBIS teams at each level—Tiers I, II, and III. Yet, many of the schools I observed failed to integrate school or community clinical professionals into their PBIS teams. There was very little, if any, interaction between community professionals and school staff past the initial referral. This concerns me because, as discussed supra in Part IV, behavioral supports and services are most effective when they are integrated in both school and the community. Instead, I observed that even students who attended a school with an operational PBIS Program were largely denied the benefits of community supports integrated into the PBIS framework.

## V. Project AWARE (Advancing Wellness and Resilience in Education)

Project AWARE is a program created through a grant from the Substance Abuse and Mental Health Services Administration ("SAMHSA"),[82] the purpose of which is to integrate mental health services and supports into schools.[83] It was developed, in part, due to the recognition that students "living with mental illness are more likely to drop out of school, enter

[81] Garry McGiboney Deposition, June 8, 2022, page 62.
[82] In partnership with the State and local systems, Project Aware works to: "1. Increase awareness of mental health issues among school-aged youth; 2. Provide training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues; and 3. Connect school-aged youth, who may have behavioral health issues (including serious emotional disturbance [SED] or serious mental illness [SMI]), and their families to needed services." Project AWARE Draft White Paper, GA00307769, Exhibit 689, Jason Byars Deposition, December 2, 2022.
[83] Jason Byars Deposition, December 2, 2022, pages 26-27, 267.

the juvenile justice system, and die by suicide."[84] GaDOE was initially awarded a five-year Project AWARE grant in 2014,[85] which resulted in 3,101 students receiving school-based mental health services.[86] In 2020, the State received a new five-year Project AWARE grant to work with three new school districts.[87]

One of the largest setbacks of Project AWARE is its limited reach in only six school districts. GaDOE did not apply for at least one subsequent grant opportunity to increase school-based mental health services. Deposition testimony suggests that this occurred, at least in part, because the different agencies could not agree to work together to implement the program if they received the grant.[88]

## VI. Georgia's Efforts to Implement its System of Care Plan

In 2010, the Georgia General Assembly directed DBHDD and GaDOE to develop and implement a state plan for the coordinated SoC for children with behavior-related disabilities.[89] The General Assembly recognized that "only a portion of the children needing services are receiving them and . . . that not all the services that compromise a coordinated system of care are currently in existence or do not exist in adequate numbers."[90] It instructed that the services provided through the State's System of Care Plan be "comprehensive, addressing the child's

[84] Project AWARE Draft White Paper, GA00307769, Exhibit 689, Jason Byars Deposition, December 2, 2022.
[85] Muscogee, Griffin-Spalding, and Newton County Schools participated in the first grant. Project AWARE draft white paper Ex. 689Project AWARE Draft White Paper, GA00307769, Exhibit 689, Jason Byars Deposition, December 2, 2022.
[86] Project AWARE Draft White Paper, GA00307769, Exhibit 689, Jason Byars Deposition, December 2, 2022.
[87] Bibb, Hall, and Houston County Schools are participating in the second grant. Georgia Project AWARE State Education Agency Grant, gadoe.org, https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Pages/Georgia-Project-AWARE.aspx.
[88] Email thread from Jason Byars to Emily Graybill, GA00310731, Exhibit 694, Jason Byars Deposition, December 2, 2022; Jason Byars Deposition, December 2, 2022, pages 311-313.
[89] GA Code § 49-5-220(c) (2010).
[90] GA Code § 49-5-220(c) (2010).

physical, educational, social, and emotional needs."[91] DBHDD created a five-year System of Care State Plan in 2011[92] and has updated that Plan twice since, in 2017[93] and 2020.[94]

Despite repeatedly setting forth appropriate goals for overseeing and monitoring the provision of services to students through an interconnected SoC,[95] Georgia does not have measurable metrics to establish a baseline or to progress monitor the implementation of its stated SoC goals. Nor has it created mechanisms to ensure necessary communication is occurring across agencies. As a result, the SoC remains fragmented and the service programs that could be integrated operate less efficiently and cause students with emotional and behavioral disabilities to not have access to the supports and services they need to remain in their home schools.

Georgia's 2020 SoC Plan specified the promising goals of "creat[ing] state capacity to track trends and outcomes across public child-serving systems to better understand the multi-system impact" and "leverage[ing] data to monitor trends and outcomes within the children's behavioral health system to inform state and local decision-makers."[96] It further explained that the vehicle for such monitoring and analysis would be a "data dashboard with identified data points on behavioral health services" and that it would "promote the statewide use of the dashboard through presentations and other communication tools."[97] It acknowledged that "ongoing evaluation of Georgia's child-serving systems is critical to sustainability and success." Unfortunately, I was unable to find evidence of data being tracked and monitored in this way.

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[91] GA Code § 49-5-222(3) (2010).
[92] Georgia System of Care Plan 2017, GA01299795, Exhibit 945, page 12, Monica Johnson Deposition, March 2, 2023.
[93] Georgia System of Care Plan 2017, GA01299795, Exhibit 945, page 13, Monica Johnson Deposition, March 2, 2023.
[94] Georgia System of Care Plan 2020, Exhibit 947, Monica Johnson Deposition, March 2, 2023.
[95] *See* Georgia System of Care Plan 2017, GA01299795, page 13, Exhibit 945, Monica Johnson Deposition, March 2, 2023; Georgia System of Care Plan 2020, Exhibit 947, Monica Johnson Deposition, March 2, 2023.
[96] Georgia System of Care Plan 2020, Exhibit 947, Monica Johnson Deposition, March 2, 2023.
[97] Georgia System of Care Plan 2020, Exhibit 947, Monica Johnson Deposition, March 2, 2023.

An interconnected SoC requires agency-level coordination, which, in Georgia, should include DBHDD and GaDOE. However, the State has not created necessary mechanisms to enable such communication. I was unable to locate any data that could be used to help identify students with emotional and behavioral disabilities across agencies. In addition, there is no formalized data-sharing across agencies to show what interventions are used or to gauge their effectiveness. Not only is this valuable interagency communication not occurring,[98] but based on my conversations with school and Apex staff, school-level communication between school and Apex staff appears to be nonexistent.

## PART VI: SERVICES FOR STUDENTS WITH BEHAVIOR-RELATED DISABILITIES ARE INSUFFICIENT IN GEORGIA

### I. Key Medicaid-reimbursable Services for Students with Behavior-related Disabilities are Under-utilized

As Georgia has acknowledged, "the ability to keep youth in their communities and to improve their functioning is directly related to the types of services and supports made available to them and their families."[99] For students with behavior-related disabilities to avoid unnecessary GNETS placements and remain in their home schools, they must be able to access appropriate therapeutic services to help meet their needs in more integrated educational settings. However, Georgia's own data show that those services are not available or not provided in sufficient quantities to children across the state.

I reviewed statewide billing data for all Medicaid-reimbursed behavioral health services for children in Georgia between 2016 and 2021. Consistently across that period, the data show that relatively few children receive the kinds of services that could improve their functioning and

[98] *See* Monica Johnson Deposition, March 2, 2023, pages 144-148.
[99] Georgia CMHS Block Grant Application FY 2020-2021, Exhibit 10, Dante McKay Deposition, January 27, 2022, page 172.

prevent their placement in more restrictive settings; even when they do, it is only in small amounts on average. The data specifically show that Intensive Customized Care Coordination, Intensive Family Intervention, and Individual Counseling Services—among other key interventions that can be provided in school- and community-based settings under Georgia's Medicaid program—are under-utilized across the state.

Intensive Customized Care Coordination ("IC3") is a provider-based High Fidelity Wraparound intervention designed for children with intensive behavioral health needs who may be at serious risk of restrictive placement. IC3 "assists individuals in identifying and gaining access to required services and supports, as well as medical, social, educational, developmental and other services and supports, regardless of the funding source for the services to which access is sought."[100] As noted above, IC3 is one of the most intensive services the State provides, and calls for doing "whatever it takes" to support children with the most intensive needs and their families. However, IC3 is especially scarce in Georgia. In 2019, only 740 children statewide received IC3 in any amount through the State's Medicaid program—less than 7 percent of the estimated total number of children in Georgia with emotional disturbances enrolled in Medicaid or PeachCare for Kids.[101] Two years later, in 2021, even fewer children (545) received IC3

[100] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 83 (January 1, 2023).
[101] According to the U.S. Department of Education, Office of Special Education and Rehabilitation Services, in SY2019, 5.45% of students with disabilities were identified with emotional disturbance. OSEP Releases Fast Facts: Children Identified With Emotional Disturbance, U.S. Department of Education, https://sites.ed.gov/osers/2020/05/osep-releases-fast-facts-children-identified-with-emotional-disturbance/, *last visited* June 13, 2023. Approximately 14.7% of students nationwide have disabilities. National Center for Education Statistics, Number and percentage of children served under Individuals with Disabilities Education Act (IDEA), https://nces.ed.gov/programs/digest/d22/tables/dt22_204.70.asp?current=yes, *last visited* June 14, 2023. *See also* CHILDREN ENROLLED IN MEDICAID OR PEACHCARE IN GEORGIA, Kids Count Data Center, *available at* https://datacenter.kidscount.org/data/tables/9691-children-enrolled-in-medicaid-or-peachcare?loc=12&loct=2#detailed/5/1927-2085/false/2048,574,1729,37,871,870,573,869,36,868/any/18930, *last visited* June 13, 2023. *See also* Children Enrolled in Medicaid or Peachcare in Georgia, Kids Count Data Center, https://datacenter.kidscount.org/data/tables/9691-children-enrolled-in-medicaid-or-peachcare?loc=12&loct=2#detailed/5/1927-2085/false/2048,574,1729,37,871,870,573,869,36,868/any/18930, *last visited* June 13, 2023.

through Georgia's Medicaid program. By contrast, more than five times as many students (3,077) were in the GNETS Program that same year.[102] Even though IC3 is an important service for supporting children in their home schools and communities,[103] Georgia until recently had authorized only two providers of the service statewide, covering all 159 counties.[104] State officials have recognized that Georgia needed more staff capacity to deliver IC3,[105] and I understand that the State has plans to add two more providers of the service.[106] Given that the two IC3 providers served so few students in prior years, I have serious concerns about whether four IC3 providers will have the capacity to adequately serve the State's students with the highest needs.

Even when Medicaid-enrolled children in Georgia receive behavioral health services, those services are often provided only in limited quantities that, based on my training and experience, are insufficient to meet the needs of many students at serious risk of GNETS placement. The State's data show that Intensive Family Intervention (IFI), another service designed for children with intensive behavior-related needs, was provided to 2,018 Medicaid-enrolled children in 2019, but that those children received on average under 7.5 hours of service – or 30 units over the course of a full year.[107] That represents approximately one-tenth of the maximum amount of the service (288 units, or 1.5 hours per week) that DBHDD authorizes providers to bill annually per child.[108] Georgia's data for 2021 shows no improvement on this point, with fewer children (1,764) receiving just 7.66 hours of IFI on average during the full year.

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[102] GaDOE December 2022 report to State Senate, GA05242582 at GA05242585.
[103] Dante McKay Deposition, January 27, 2022, page 132.
[104] Dante McKay Deposition, January 27, 2022, pages 118-119.
[105] Wendy Tiegreen Deposition, June 21, 2022, pages 211-212.
[106] Dante McKay Deposition, January 27, 2022, page 133.
[107] As set by DBHDD, the relevant unit of service for IFI is 15 minutes. *See* DBHDD FY23 BH Service Provider Manual 94 (January 1, 2023).
[108] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 15 (January 1, 2023).

Similarly, while a much a larger number of children in Georgia are receiving Individual Counseling, the average of amount of service provided per child annually is significantly lower than I would expect, suggesting that the service is not being provided in sufficient quantities. Georgia reports that 40,711 children statewide received Individual Counseling in 2021, down from 41,211 children in 2019. But in each of those years the average amount of Individual Counseling provided was around 5.75 hours – as little as six counseling sessions for the entire year.[109] Based on my experience, this is nowhere near the amount of service that would typically be required to meet the needs of most students with significant behavioral needs who would be at serious risk of restrictive educational placement. Indeed, as discussed below, most children in GNETS in School Years 2020 and 2022 received little to no Individual Counseling in the months leading up to their placement in GNETS. *See infra* at Part VII.

## II. The Limited Reach and Muted Impact of Georgia's Apex Program

My interviews of school and district staff participating in Apex, as well as testimony by Apex providers in different regions of the state, underscored the program's benefits and its shortfalls. Participating schools receive important additional resources through Apex as they strive to support students with behavior-related disabilities in their communities. One principal stated that her school would not be able to meet the needs of students with behavior-related disabilities but for the Apex Program.[110] However, Apex participants also consistently identified a need for more funding and support to build the program's capacity. As the State's data reporting reflects, there are still far too many schools in Georgia that do not have access to the behavioral health services available through Apex. And even among participating schools, the

[109] As set by DBHDD, the relevant unit of service for Individual Counseling can be 30 minutes, 45 minutes, or one hour. *See* FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 150 (January 1, 2023).
[110] February 27, 2023 Early County High School site visit.

services provided through Apex are not provided in sufficient amounts or are not sufficiently intensive to meet the needs of students at serious risk of restrictive educational placements.

I reviewed State reports on the services that students received through the Apex Program during School Years 2020, 2021, and 2022 (Apex Year 5 through Year 7).[111] For each school year, the data included the most common diagnoses of students who received services through Apex, the primary reasons students were referred to the Apex Program, the number of unique students who received services, the number of services delivered, and the most common services provided.

Although the Apex Program presents a much-needed opportunity to deliver behavioral health services in school-based settings, it is not widely available to most students in Georgia, regardless of their need for therapeutic services to avoid restrictive placement in GNETS facilities. In SY2022, the Apex Program served only 13,778 of the State's over 1.6 million public school students.[112] This equates to less than *one percent* of all public-school students in Georgia, even though national estimates suggest that roughly 20 percent of students at any one time have behavior-related needs.[113]

As of SY2022 (Apex Year 7), the State's own data show that only 738 of over 2,200 public schools in Georgia – or approximately 33.5% – participated in the Apex Program.[114] The State considered an even fewer 704 schools "engaged partners," meaning that those schools

[111] The Apex Program completed its seventh year in SY2022. Apex 3.0 FAQs, Exhibit 978, Dante McKay 30(b)(6) Deposition, March 9, 2023.
[112] Apex Y7 Annual Evaluation Slide Deck, GA05558501 at GA05558512; Schools and Districts, Georgia Department of Education, https://www.gadoe.org/External-Affairs-and-Policy/AskDOE/Pages/Schools-and-Districts.aspx.
[113] Improving Access to Children's Mental Health Care, Centers for Disease Control and Prevention, https://www.cdc.gov/childrensmentalhealth/access.html#ref.
[114] Apex Y7 Annual Evaluation Slide Deck, GA05558501 at GA05558511; Schools and Districts, Georgia Department of Education, https://www.gadoe.org/External-Affairs-and-Policy/AskDOE/Pages/Schools-and-Districts.aspx.

submitted three or more months annually of Apex-related reporting data to the State.[115] From SY2020 to SY2022, the number of schools participating in Apex has increased by 108.[116] If schools continue to join Apex at this pace, it will take more than a decade for 100% of Georgia's schools to participate in Apex. While DBHDD wants to expand the Apex Program statewide, it has not conducted any analysis of how much additional funding that would require.[117]

The State's own data show that its Apex service providers deliver far too few Tier II and Tier III services to far too few students. For example, in April 2021 (in Apex Year 6), Apex service providers delivered Tier II and Tier III services to just 6,196 of the State's over 1.6 million public school students.[118] In every other month that school year, even fewer students received Tier II and Tier III services through Apex.[119] Further, that same month (April 2021), Apex providers did not deliver Group Outpatient Services in 95% of the schools (see Figure 1, below); did not conduct any Diagnostic Assessments in 75% of schools; did not provide any Psychiatric Treatment services to 56% of schools (see Figure 3 below); and did not deliver any Community Support in 49% of participating schools.[120] And that same month in 88% of schools, Apex providers delivered 20 or fewer units of Individual Outpatient Services per school.[121]

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[115] Apex Y7 Annual Evaluation Slide Deck, GA05558501, at GA05558511.
[116] Year 5 Apex Eval Results Slideshow, GA01749707, page 13 (showing 630 Apex schools); GA05559744 Apex Y6 Annual Evaluation Slide Deck at GA05559756 (showing 731 Apex schools); Apex Y7 Annual Evaluation Slide Deck, GA05558501, at GA05558511 (showing 738 Apex schools).
[117] Dante McKay Deposition, January 27, 2022, pages 186-187.
[118] Year 6 Monthly Progress Reports: July 2020 through June 2021, GA05559718-GA05559728.
[119] The State's SY2021 Apex data represents the most recent year of complete, usable Apex data that Georgia has produced to the United States to date.
[120] Year 6 Monthly Progress Reports: July 2020 through June 2021, GA05559718-GA05559728. DBHDD defines Diagnostic Assessments as "[p]sychiatric diagnostic interview examination[s]" used to evaluate and assess physiological phenomena and to assess the "appropriateness of initiating or continuing services." FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers 32 (January 1, 2023). Providers conduct Diagnostic Assessments to determine the particular interventions students need. The DBHDD provider manual defines Psychiatric Treatment services as "[p]sychotherapeutic services with medical evaluation and management including evaluation and assessment of physiological phenomena." Providers use these services to assess "the appropriateness of initiating or continuing services." FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 51 (January 1, 2023).
[121] Year 6 Monthly Progress Reports: July 2020 through June 2021, GA05559718-GA05559728.

These Tier II and Tier III services are specifically designed for "at-risk students with emerging behavioral health needs" (Tier II) and for students "living with a behavioral health diagnosis," (Tier III)[122] and in my opinion would be the most beneficial Apex services for students at serious risk of GNETS placement, yet they are in short supply. This is consistent with data from the prior year.

In March 2020 (in Apex Year 5), Apex providers delivered Tier II and Tier III services to only 6,594 students, the most students served in any month during that school year.[123] Yet, that month, Apex providers did not deliver Group Outpatient services in 93% of schools (see Figure 2 below); did not conduct any Diagnostic Assessments in 72% participating schools; did not provide Psychiatric Treatment services in 53% of schools (see Figure 4 below); and did not deliver Community Support in 41% of schools.[124] And that same month in 90% of schools, Apex providers delivered 20 or fewer total units of Individual Outpatient Services per school.[125] The small amount of schools at which Apex providers delivered Group Outpatient and Psychiatric Treatment services is illustrated in Figures 1 through 4 below.

[122] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 57 (January 1, 2023).
[123] Year 5 Monthly Progress Reports: July 2019 through June 2020, GA01477802-GA01483474.
[124] Year 5 Monthly Progress Reports: July 2019 through June 2020, GA01477802-GA01483474.
[125] Year 5 Monthly Progress Reports: July 2019 through June 2020, GA01477802-GA01483474.

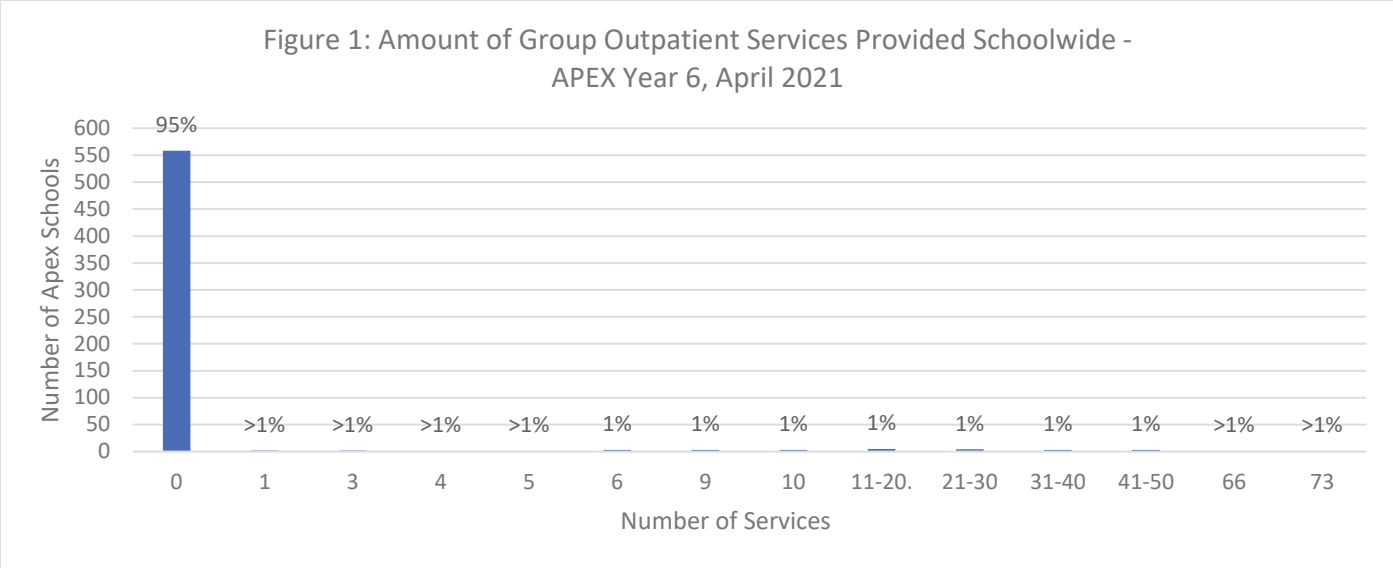


Figure 1: Amount of Group Outpatient Services Provided Schoolwide - APEX Year 6, April 2021
Number of Apex Schools
600
550
500
450
400
350
300
250
200
150
100
50
0
95%
>1%
>1%
>1%
>1%
1%
1%
1%
1%
1%
1%
1%
>1%
>1%
0
1
3
4
5
6
9
10
11-20.
21-30
31-40
41-50
66
73
Number of Services

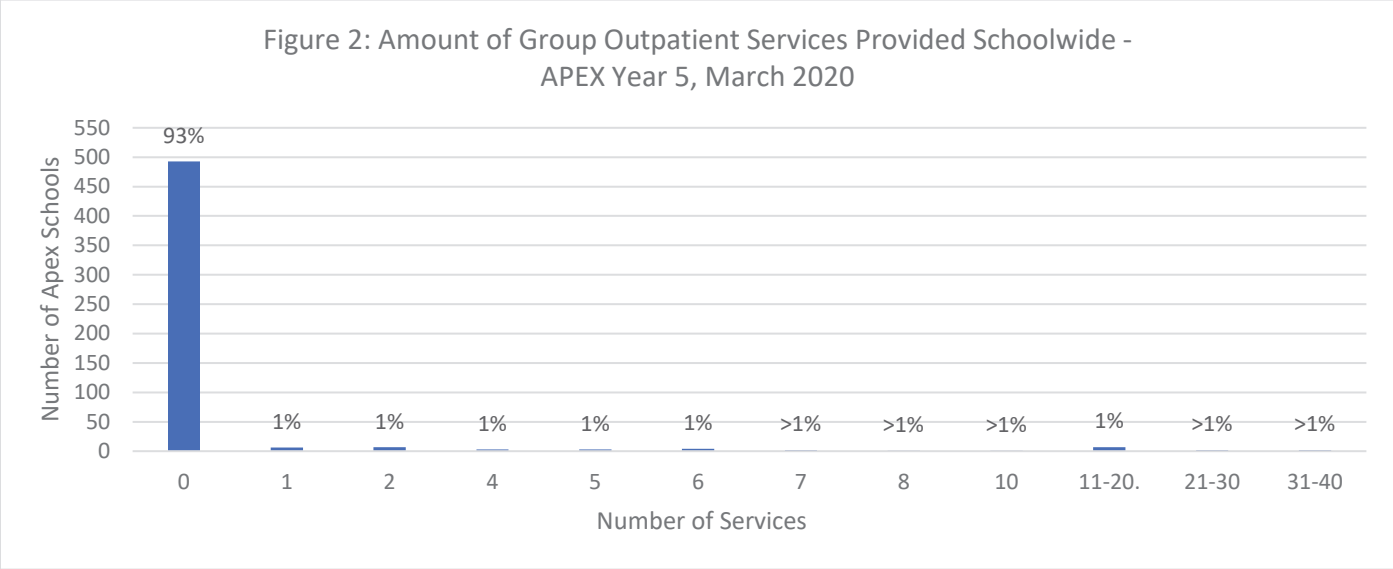
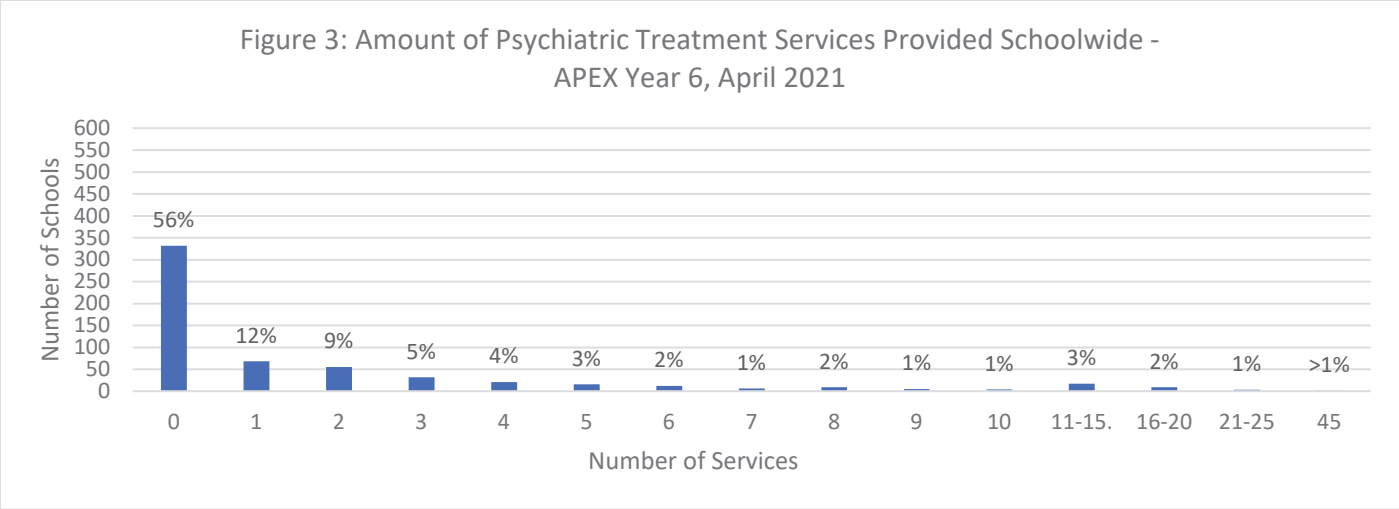
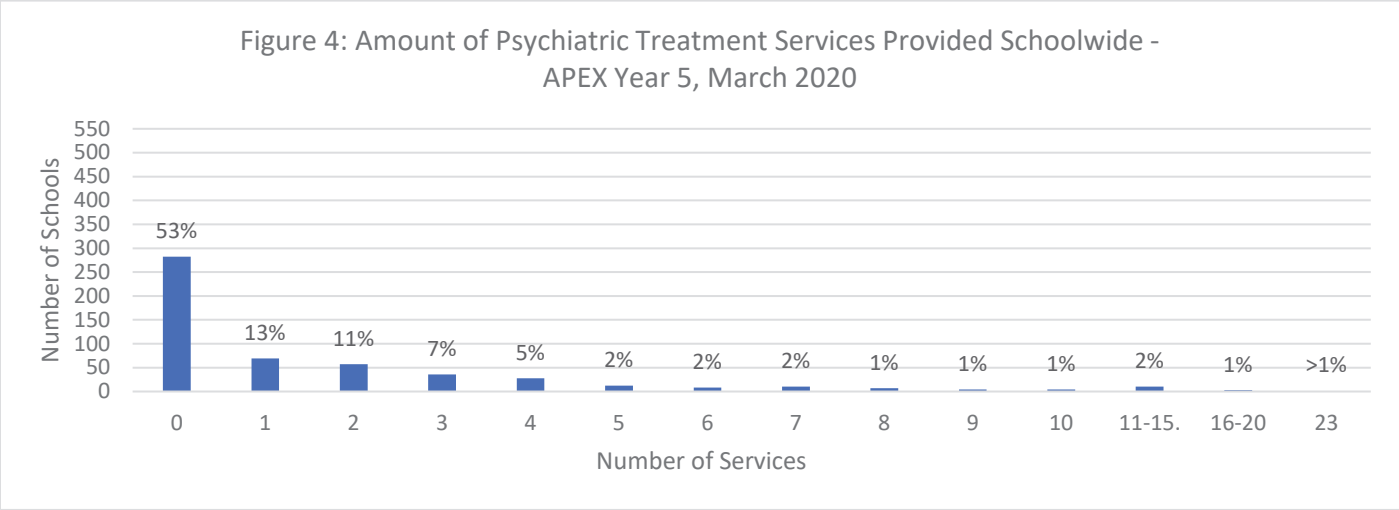


Figure 2: Amount of Group Outpatient Services Provided Schoolwide - APEX Year 5, March 2020
Number of Apex Schools
550
500
450
400
350
300
250
200
150
100
50
0
93%
1%
1%
1%
1%
1%
>1%
>1%
>1%
1%
>1%
>1%
0
1
2
4
5
6
7
8
10
11-20.
21-30
31-40
Number of Services




Not only has the State failed to provide a sufficient amount of Apex services in general, the State has also failed to ensure that the particular services most important for the highest need students are provided in sufficient quantity and intensity. Based on the State's Apex model, in SY2022 (Apex Year Seven), approximately 80,000 students statewide needed Tier III services, the program's most intensive interventions.[126] Based on my experience serving children with

[126] Georgia's Apex Program model defines Tier III as 3-5% of the student population. Apex Year 7 Evaluation Slide Deck, GA05558501 at GA05558503. See Allen deposition at 95-99. Five percent of the State's roughly 1.6 million students equates to approximately 80,000 students.

intense needs, I would expect that each of those 80,000 students would need to receive Individual Outpatient and/or Group Outpatient services. However, the State delivered Tier II and Tier III services to only 13,778 total students that school year. That means each student fortunate enough to receive any Tier II and Tier III Apex services that school year received an annual average of less than 5 units of Individual Outpatient services and less than one unit of Group Outpatient services.[127] In my experience, a student exhibiting the types of behaviors that would put them at serious risk of GNETS placement would typically need services of the type provided by Apex multiple times (units) per month to remain in a general education setting.

During SY2020 (Apex Year Five), the State's approximately 85,000 highest-need students similarly received an insufficient number of services.[128] State Apex providers delivered a monthly average of only 7 Tier III services per school.[129] Because the State's providers only delivered Tier II and Tier III Apex services to 15,607 students,[130] each student received an average of fewer than three units of Individual Outpatient services and less than one unit of Group Outpatient services. Based on this data, it is my opinion that the State is not adequately leveraging the Apex Program to ensure that its highest need students receive the support they need to remain in integrated settings.

In addition, the State has failed to utilize Apex to provide some of its most high intensity services. For example, in the entire SY2021 (Apex Year Six), State Apex providers delivered a mere 12 units of Georgia's High-Fidelity Wraparound intervention, Intensive Customized Care

[127] Apex Year 7 Evaluation Slide Deck, GA05558501 at GA05558520. (Showing the State provided only 63,089 Individual Outpatient services and 11,284 Group Outpatient services in SY2022.)
[128] In SY2020, five percent of the State's roughly 1.7 million students equated to 85,000 students. GaDOE Fiscal Year 2020-3 Data Report, Georgia Department of Education, https://oraapp.doe.k12.ga.us/ows-bin/owa/fte_pack_enrollgrade.entry_form.
[129] Year 5 Apex Eval Results Slideshow, GA01749707, page 50.
[130] Year 5 Apex Eval Results Slideshow, GA01749707, page 21.

Coordination (IC3), and 1 unit of Intensive Family Intervention (IFI) total statewide.[131] Given the ample research showing services like IC3 and IFI can support students with emotional and behavioral disabilities and allow them to remain in more integrated settings, *see supra* Part III, the State's service utilization rates are grossly inadequate. Indeed, the State's manual for providers instructs staff to coordinate with students receiving IC3 services, their caregivers, or other members of students' IC3 teams, "an average of three hours" each week with one face-to-face meeting weekly for an average of "12-18 months "[132] and—when providing IFI services—to "offer a minimum of 3 contacts per week with the youth/family."[133] The State's IC3 and IFI service delivery has fallen far short of its own standards.

## PART VII: SERVICES ARE PARTICULARLY LACKING FOR STUDENTS AT SERIOUS RISK OF ENTERING GNETS

Despite the State's acknowledgement of the importance of intensive therapeutic services in supporting children in general education classrooms and avoiding segregated placements, the State fails to ensure that children with high needs – specifically those who enter GNETS[134] – receive those services as needed. I reviewed data showing the Medicaid-billed services that students in GNETS in SY2020 and SY2022 received during a five-year period from 2017 through 2022 in order to assess whether they received the intensive therapeutic services that might have helped them avoid GNETS placement. Unfortunately, many students who ultimately were sent to GNETS did not receive these Medicaid-reimbursable intensive therapeutic services before they entered GNETS. As a result of these service deficiencies, children continue to be sent to GNETS, and other students remain at serious risk of being sent to GNETS, when they

[131] Apex Y6 Annual Evaluation Slide Deck, GA05559744, at GA05559767.
[132] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 83-84 (January 1, 2023).
[133] FY 23 Ga. DBHDD Provider Manual for Community Behavioral Health Providers, page 99 (January 1, 2023).
[134] GNETS is intended to serve students "who exhibit intense social, emotional and/or behavioral challenges . . . ." GNETS Rule, GA. COMP. R. & REGS. 160-4-7-.15(2)(a).

might otherwise be able to remain in general education settings if provided the appropriate services and supports.

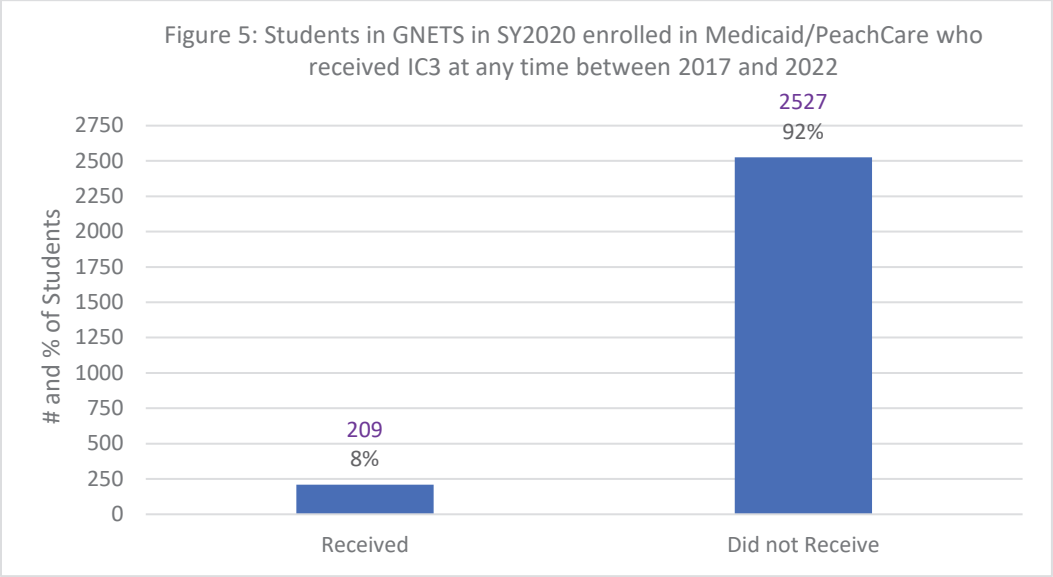
The vast majority of students in GNETS are enrolled in Medicaid or PeachCare. For example, in SY 2020, 2,736 (81.8%) of the 3,344 students in GNETS were enrolled in Medicaid or PeachCare at some point between SY 2016 and SY 2020.[135] Similarly, in SY 2022, 2,396 (81.4%) of the 2,942 students in GNETS were enrolled in Medicaid or PeachCare for at least one quarter between SY 2016 and SY 2022. But many of these students never received therapeutic Medicaid services, despite the fact that they are eligible for those services and that those services are designed to support children with behavioral health needs and help them avoid placement in a restrictive setting. In fact, over *one-third* (34.4%) of the students in GNETS in SY2020 who were Medicaid- or PeachCare-enrolled did not receive any Medicaid services between 2017 and 2022. And of the 1,794 students who received services at any time in that five-year period, 56 students only received an assessment[136] without any additional services.

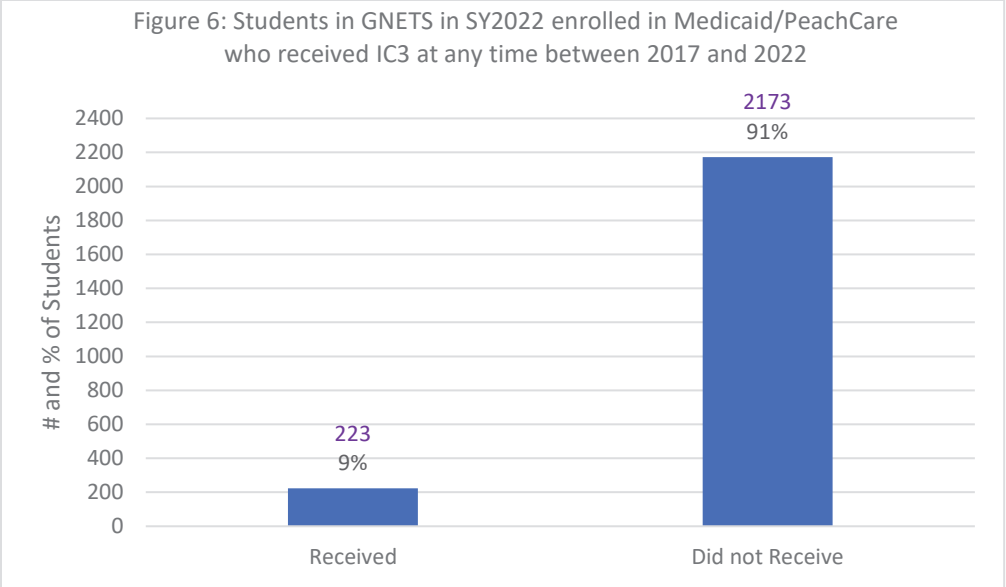
This trend has continued. More than one-quarter (26.8%) of the 2,396 students in GNETS in SY2022 who were enrolled in Medicaid/PeachCare did not receive any Medicaid services between 2017-2022. And again, more than 50 of those students (54) received only an assessment. The therapeutic Medicaid services the students did receive were often provided in small amounts or to just a tiny fraction of students. A few services stand out for mention.

Intensive Customized Care Coordination ("IC3") is a provider-based High-Fidelity Wraparound intervention. As noted above, IC3 is one of the most intensive services the State

[135] The data sets produced by the State were not fully consistent. There were occasions where a student was listed as enrolled in Medicaid or PeachCare for one quarter in one data set, but not in another. *Compare* GA00265967 *with* GA05559839. Where there were discrepancies, I relied on the most recent data from the State.
[136] Assessment includes Nursing Assessments and Health, Behavioral Health Assessments, Diagnostic Assessments, and Psychological Testing.

provides designed to support children with the most intensive needs and their families. Although IC3 is specifically designed for students with intensive needs, the vast majority of students in GNETS never received IC3 – before, during, or after being placed in their restrictive educational environments. Just 8% (209) of the students in GNETS in SY2020 who were enrolled in Medicaid or Peach Care received IC3 at any time between 2017-2022. This percentage increased slightly for students in GNETS in SY2022, when 9% (223) of the students received IC3 at any time between 2017 and 2022. See Figures 5 and 6 below.



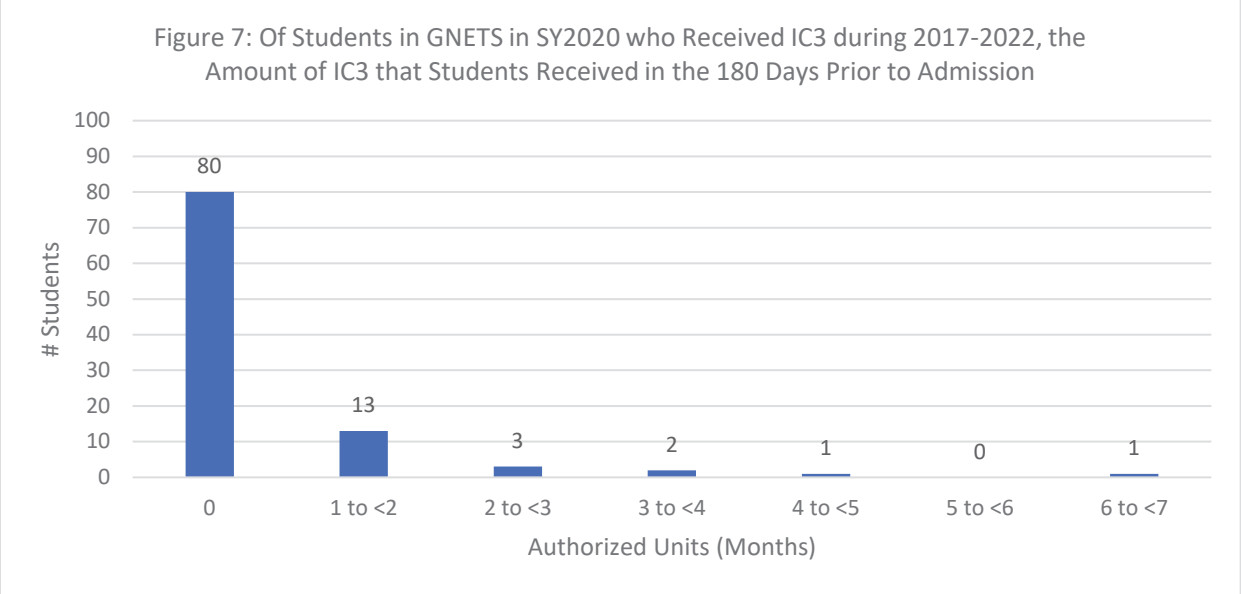



I also reviewed data showing when students received services relative to the date of their admission to GNETS, in order to assess whether they received those services in a timely way such that the services might have diverted them from a restrictive placement in GNETS.[137] Unfortunately, even fewer students in GNETS received IC3 before their admission to GNETS.

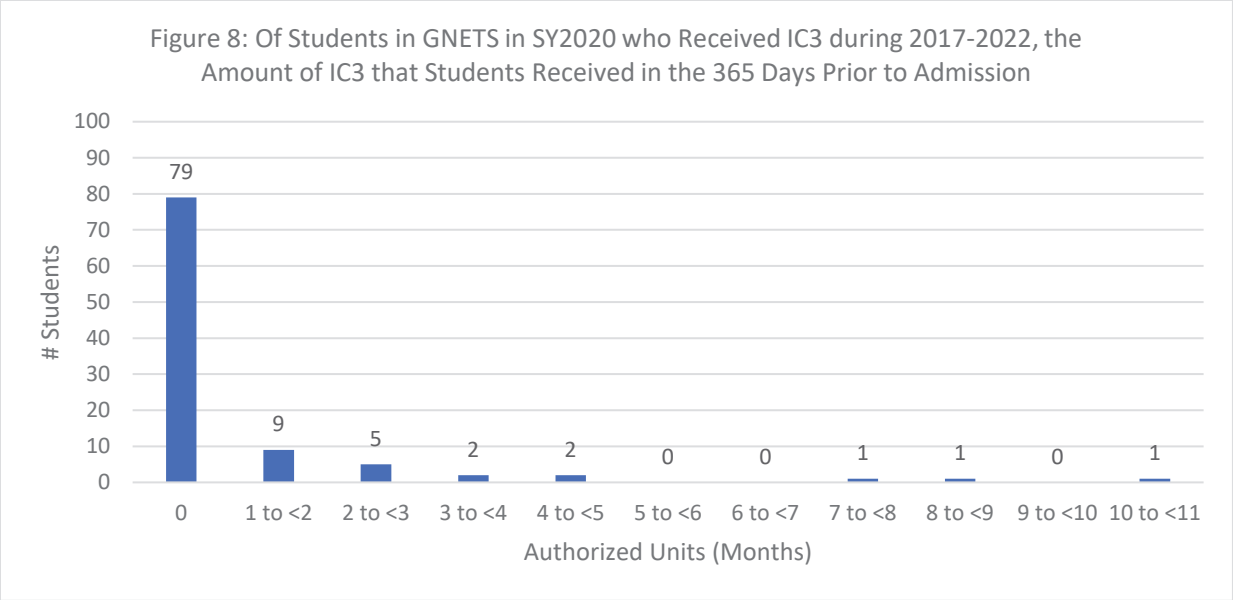
There were 1,171 Medicaid/PeachCare-enrolled students who were in GNETS in SY2020 and admitted to GNETS for the first time between 2018 and 2020. 100 of those students (8.5%) received IC3 at any time between 2017 and 2022. However, just *twenty students* who received IC3 at any time between 2017 and 2022 received the service in the 180 days prior to being admitted to GNETS (and *eighty* students did not). See Figure 7 below. When I expanded the timeframe to look at the full year prior to each student's admission, this number only increased by one student to twenty-one students; in other words, of the 100 students who received IC3 at any time between 2017 and 2022, 79 of them did not receive it in the full year prior to their

[137] For this analysis, I limited my review to students who were enrolled in GNETS for the first time in Calendar Year 2018 through CY 2020. Students enrolled in 2017 and earlier were excluded, because I did not have access to data about the Medicaid services students received prior to 2017. I also excluded any students enrolled in GNETS for the first time in Calendar Year 2018 through CY 2020 where I could not confidently match their names in the GNETS enrollment data with their names in the Medicaid services data, typically because of slight differences in spelling, hyphenated last names, or apostrophes.

admission to GNETS. See Figure 8 below. This means that *fewer than 2%* of all Medicaid/PeachCare-enrolled students who were admitted to GNETS for the first time between 2018 and 2020 received IC3 in the year prior to their admission to GNETS. Further, as shown in the figures below, even for the children who received IC3 in the 180-days or year prior to their admission to GNETS, most received just one or two months of service.[138]

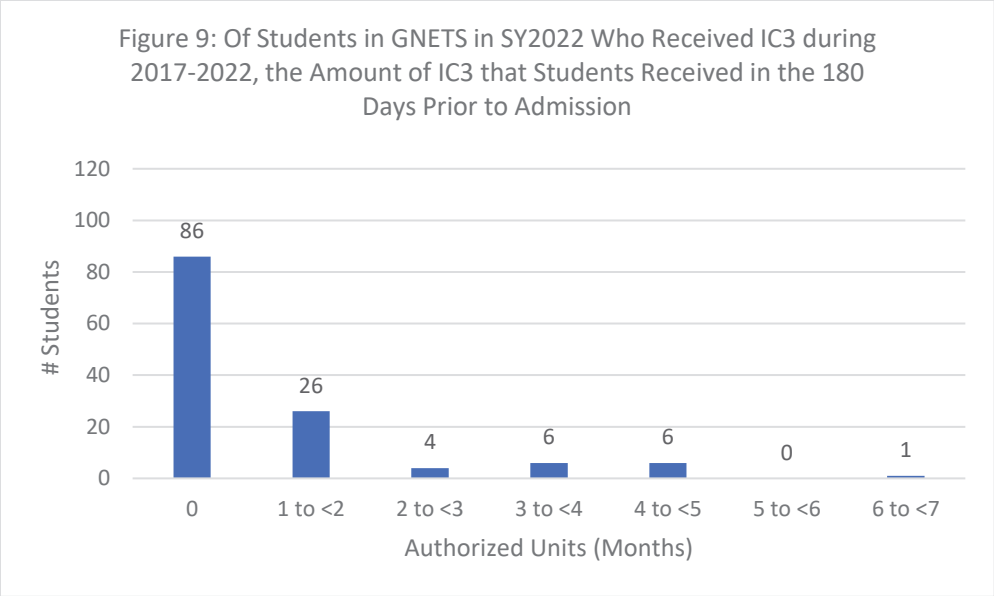


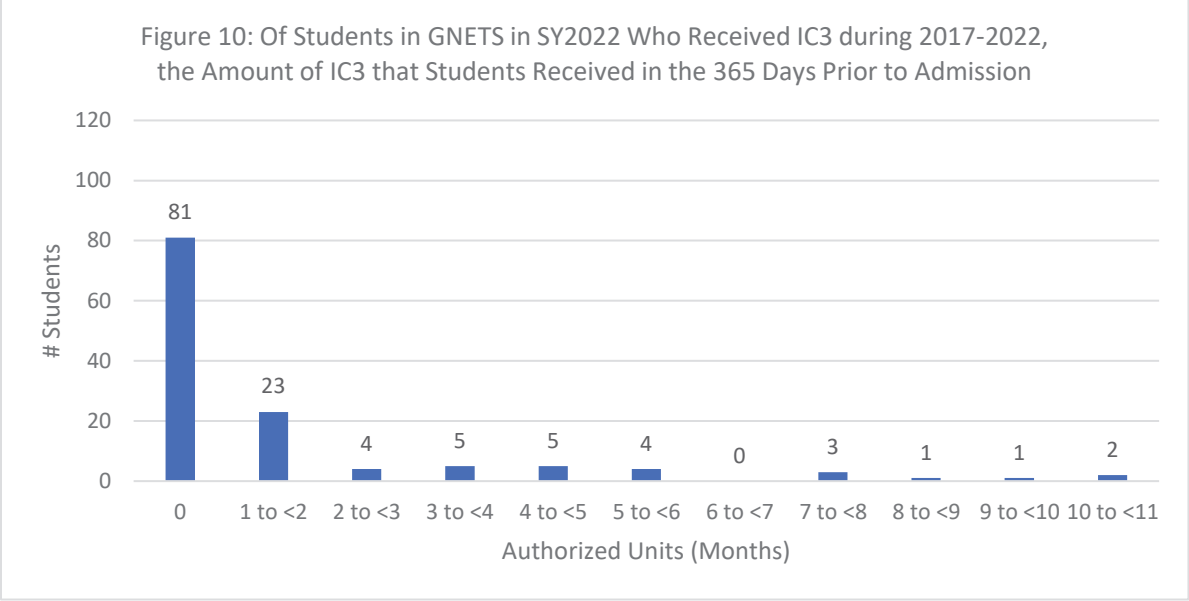

[138] For these calculations, I considered any student who received less than 0.5 units of a service during the relevant time period as receiving zero units of the service. Any student who received 0.5 units to 1.0 units was counted as receiving one unit of the service.




These trends were consistent for students in GNETS in SY2022. There were 1,489 Medicaid/PeachCare-enrolled students in GNETS in SY2022 who were admitted to GNETS for the first time between 2018 and 2022.[139] 129 of those 1,489 students (8.7%) received IC3 at any time between 2017 and 2022. However, only 43 of those 129 students received IC3 in the 180 days prior to their admission to GNETS (and 86 did not). And only 48 students received IC3 in the year prior to their admission (and 81 did not). See Figures 9 and 10 below. This translates to *just over 3%* of students in GNETS in SY2022 who received IC3 in the year prior to their admission to GNETS. More information about the amount of IC3 that students received in the 180 days and year prior to their admission to GNETS is set out in the figures below.

[139] Similar to the analysis above, I limited my review to students who were enrolled in GNETS for the first time in Calendar Year 2018 through CY 2022. Students enrolled in 2017 and earlier were excluded, because I did not have access to data about the Medicaid services students received prior to 2017. As above, I also excluded any students enrolled in GNETS for the first time in Calendar Year 2018 through CY 2022 where I could not confidently match their names in the GNETS enrollment data with their names in the Medicaid services data, typically because of slight differences in spelling, hyphenated last names, or apostrophes.

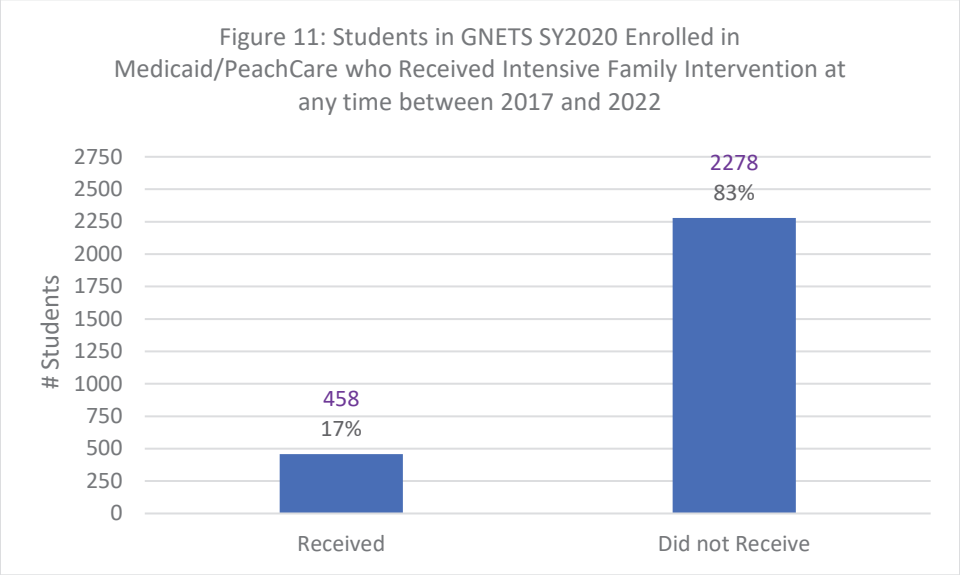


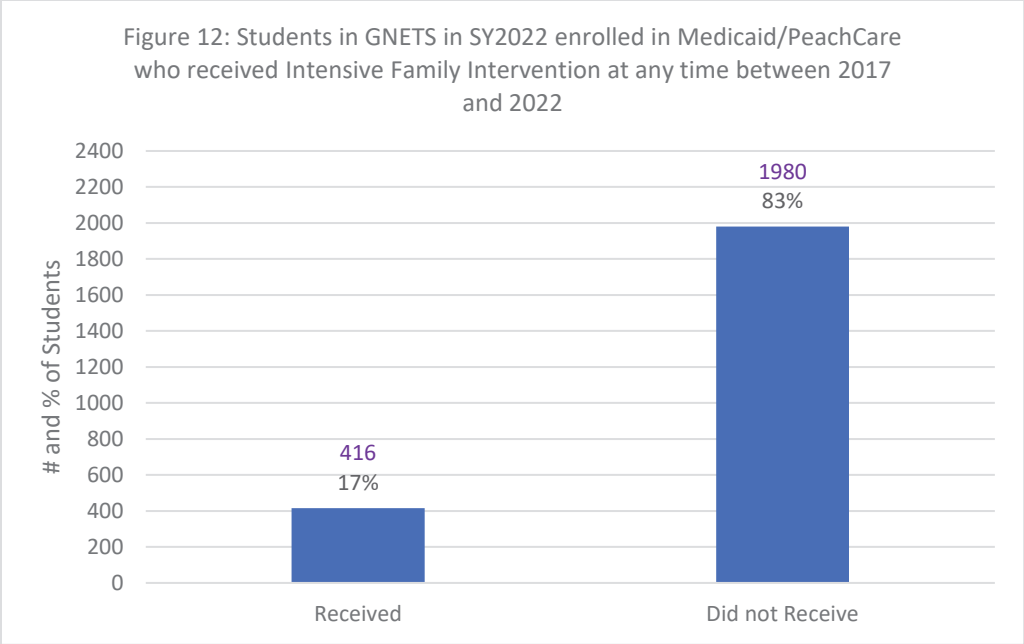

Another service designed for children with intensive behavior-related needs that has been underutilized for students at serious risk of placement in GNETS is Intensive Family Intervention. This service is "intended to improve family functioning by clinically stabilizing the living arrangement, promoting reunification or preventing the utilization of out of home therapeutic venues . . . for the identified youth."[140] Although this service can help stabilize

[140] FY 23 Provider Manual for Community Behavioral Health Providers, page 94 (January 1, 2023).

children in their homes and schools, just 17% of the Medicaid- or Peach Care-enrolled students in GNETS in both SY2020 and SY2022 received Intensive Family Intervention at any time between 2017 and 2022. See Figures 11 and 12. Moreover, approximately half of the students who received Intensive Family Intervention did not receive it in the six months prior to their admission to GNETS—the time-period when in my experience it is typically most effective in helping the student avoid a more restrictive placement. Of the students who received Intensive Family Intervention, 91 students (48.4%) in GNETS in SY2020 and 111 students (51.2%) in GNETS in SY2022 received no Intensive Family Intervention in the 180 days prior to GNETS admission.[141]



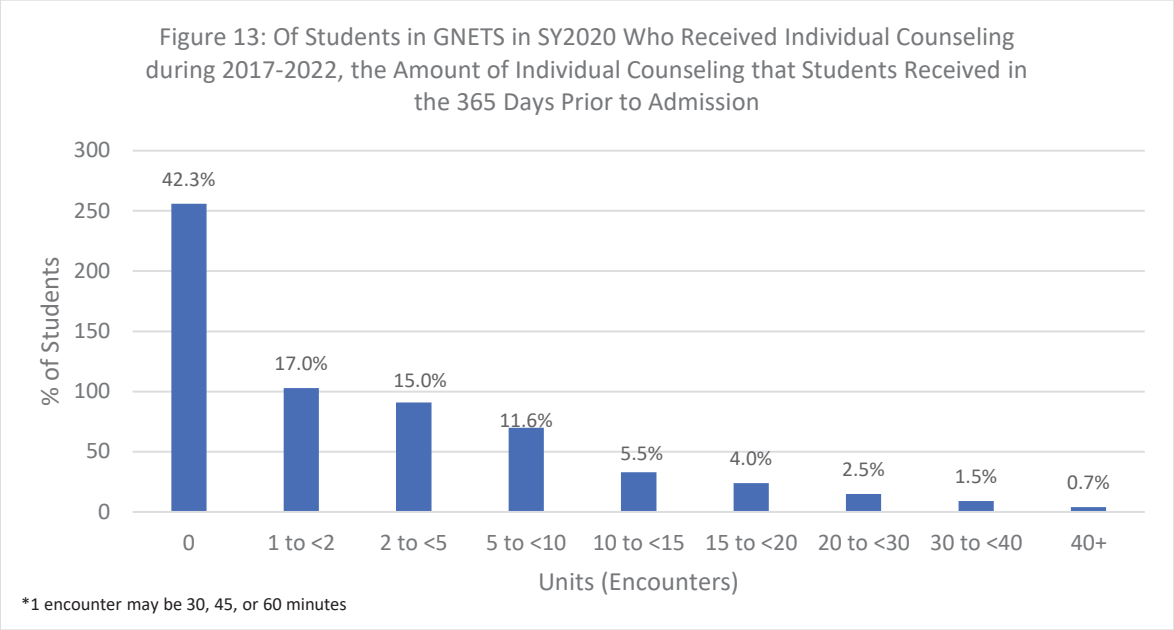

[141] As above, this data is based on my review of Medicaid- or PeachCare-enrolled students who received Intensive Family Intervention at any point the five-year period from 2017-2022 and who were admitted to GNETS for the first time between 2018 and 2020 (for the SY2020 cohort) or between 2018 and 2022 (for the SY2022 cohort).



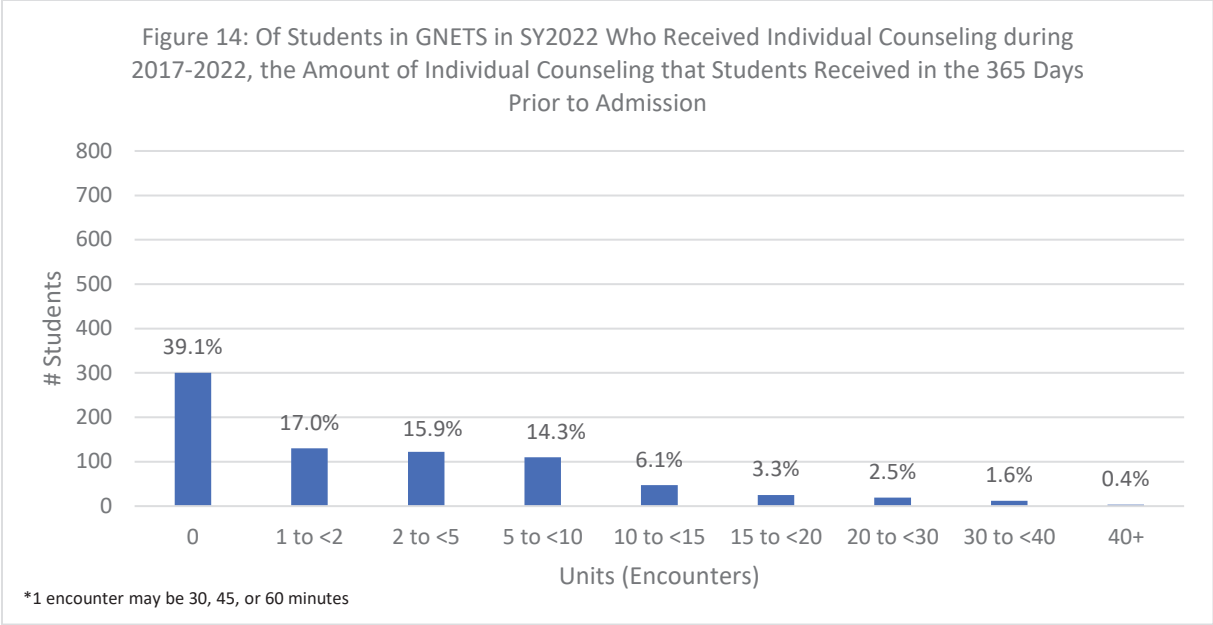

Other services were provided with even less frequency. For example, Group Counseling, although acknowledged to be an effective intervention for children with EBD, was provided to just 3% of the Medicaid/PeachCare-enrolled students in GNETS in SY2020 and SY2022 at any time from 2017 to 2022. On average, these students received less than 4 hours total of group counseling over this five-year period. Behavioral Health Clinical Consultation was provided to just *two* students who attended GNETS in SY2020 during the five years from 2017 to 2022, and appears not to have been provided to any students who attended GNETS in SY2022.

Finally, although I would anticipate that any student identified as having intensive behavioral needs other than those with very limited communication skills would receive individual counseling on an ongoing basis prior to placement in a restrictive setting, almost half of all Medicaid- or PeachCare-enrolled GNETS students in SY2020 (49.0%) and more than 40 percent of such GNETS students in SY2022 (42.3%) did not receive individual counseling at any time between 2017 and 2022. Furthermore, only 25% of Medicaid- or PeachCare-enrolled GNETS students in SY2020 and 26% of students SY2022 received individual counseling in the

180 days prior to being admitted to GNETS.[142] In fact, as shown in the figures below, of the students in GNETS in SY2020 who received individual counseling at all between 2017 and 2022, approximately *sixty percent* either received no counseling in the year leading up to their admission to GNETS or received just 1 to 2 counseling sessions. See Figure 13. These numbers scarcely improved for students in GNETS in SY2022. See Figure 14.




[142] As above, this data is based on my review of Medicaid or PeachCare-enrolled students who were admitted to GNETS for the first time between 2018 and 2020 (for the SY2020 cohort) or between 2018 and 2022 (for the SY2022 cohort).




In order to better see how this lack of services impacts students who were admitted to GNETS, I pulled the records of a few students at random in GNETS in SY2020 and SY2022 who were enrolled in Medicaid or PeachCare. Specifically, I pulled the records of four students at random from the SY2020 cohort and three students at random from the SY2022 cohort. It is notable that out of these seven students, at least two (one from each cohort) were enrolled in Medicaid/PeachCare and were admitted to GNETS, but received no Medicaid services at all from 2017-2022. Below is a description of the services received by two different students, one from each cohort.

In January 2020, Tyler,[143] a Latino 7th grader with EBD, entered GNETS. Tyler was enrolled in Medicaid/PeachCare during that SY2020, and he remained enrolled through SY2022. However, Tyler did not receive any therapeutic Medicaid services prior to his admission to GNETS.

[143] To protect students' privacy, I have selected pseudonyms for the individual students discussed in this report.

Even after he entered GNETS, Tyler did not receive sufficient therapeutic Medicaid services to support his transition back to a more integrated placement. Although Tyler entered GNETS in January 2020, he did not receive any therapeutic Medicaid services until the following school year, in 2021. When he eventually received some therapeutic Medicaid services, he only received small amounts. During SY 2021, Tyler received only three units of Individual Counseling, and he did not receive any Community Support until 2022. There is no indication in the record that Tyler ever received IC3. During SY 2021 and SY2022, Tyler received 19 units of Individual Counseling, an average of less than one unit per month. Had Tyler received therapeutic interventions through Medicaid prior to his referral to GNETS, he might have spent his 7th and 8th grade years in a general education environment. Instead, he spent over two years in a restrictive GNETS placement.

The student I reviewed from the SY2022 cohort similarly did not receive Medicaid services in sufficient amounts to prevent his admission to GNETS. Kevin, a white 9th grader with EBD, entered GNETS in January 2022. He had been enrolled in Medicaid/PeachCare since the beginning of that school year. Kevin received few therapeutic Medicaid services before he entered GNETS. In the 180 days prior to his admission, other than assessments, he received just 0.8 units of Psychiatric Treatment and 2.5 units of Individual Counseling. He did not receive IC3 any time in the year before his GNETS admission. The minimal therapeutic services that the State provided Kevin prior to 2022 did not offer him the intensive support he needed to avoid a restrictive placement in GNETS.

The kinds of Medicaid-reimbursable therapeutic school-based services that can help students at serious risk of GNETS placement remain in their home schools already exist in Georgia. *See supra* at Parts V, VI. These include IC3, IFI, individual and group counseling, and

Behavioral Health Clinical Consultation. But few students receive these services, either at all or in sufficient amounts, before entering GNETS' highly restrictive, segregated setting. By ensuring that appropriate services are available and provided to students when they need them most, the State could prevent many unnecessary GNETS placements.

## PART VIII: REASONABLE STEPS GEORGIA COULD TAKE TO PREVENT UNNECESSARY GNETS PLACEMENTS

As discussed above, children who manifest significant behavior needs while attending public schools in Georgia frequently do not receive appropriate services and supports in their home schools before being placed in GNETS facilities. *See supra* at Parts V-VII. In my expert opinion, Georgia can make reasonable modifications to its service system to enable such students to remain in their home schools and prevent their unnecessary placement in GNETS facilities. Georgia can achieve this by: (1) expanding its existing programs to ensure timely access to individualized planning, services, and supports as appropriate, including intensive behavioral health services for students at serious risk of restrictive educational placement; (2) ensuring that those services are provided consistent with established standards relating to service intensity, early identification and intervention, and PBIS; (3) ensuring that school administrators and teachers receive ongoing, effective training and mentoring on inclusionary practices and services for students with behavior-related disabilities; and (4) improving coordination through its existing System of Care, including data collection and information exchange between and by the relevant child-serving State agencies and other relevant stakeholders.

### I. Expanding Existing School-based Behavioral Health Services

The types of behavioral health services that can help students with behavior-related disabilities remain in their home schools and avoid unnecessary GNETS placement already exist in Georgia. Intensive Customized Care Coordination (IC3), Intensive Family Intervention (IFI),

Individual and Group Counseling, and Community Support—among other key services—have been available for years through Georgia's Medicaid system. DBHDD acknowledges that these services are effective and has begun improving access to them in school settings through the Apex Program, piloted in 2015, among other initiatives. As of July 2022, however, Apex has reached less than 34 percent of schools in the state, despite strong interest from service providers and schools[144] in making school-based behavioral health services widely available. *See supra* at Part VI. My experience shows, and research confirms, that Georgia can expand its existing programs to ensure that students across the state have access to the services they need to remain in their home schools where appropriate. Furthermore, the State has at its disposal substantial state and federal funding, discussed below, to support that expansion.

### A. Using Proven Strategies to Replicate Successes of Other States and Districts

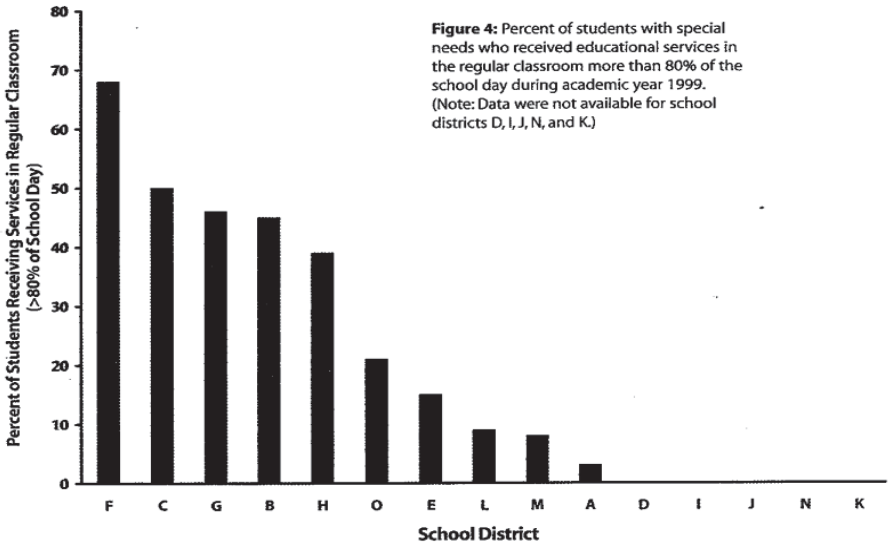
Over the past forty years of my career, I have seen school districts implement and sustain inclusionary practices and limit their reliance on restrictive placements for students with behavior-related disabilities. For example, I worked with a team to provide behavioral consultation to a large school district in Massachusetts concerning students with EBD identified as being at high risk of segregated placements in general education schools or separate facilities. Our team consulted with classroom staff and in-school service providers about improving individual behavior support practices and classroom management practices geared toward meeting the needs of this population in more integrated educational settings. In addition, we consulted the district about the use of inclusionary services relating to classroom management, co-teaching, and addressing challenging behavior. With our guidance, the district implemented

[144] At public schools participating in Apex that I visited, I heard many favorable reviews of APEX services, but always with a comment that, in substance, Georgia needs to expand the program exponentially. In schools that do not have the Apex Program, I heard repeatedly about the lack of availability of behavioral health services.

these practices and services in roughly 25 schools, leveraging available local, state, and federal resources and existing school staff and community service provider partners.

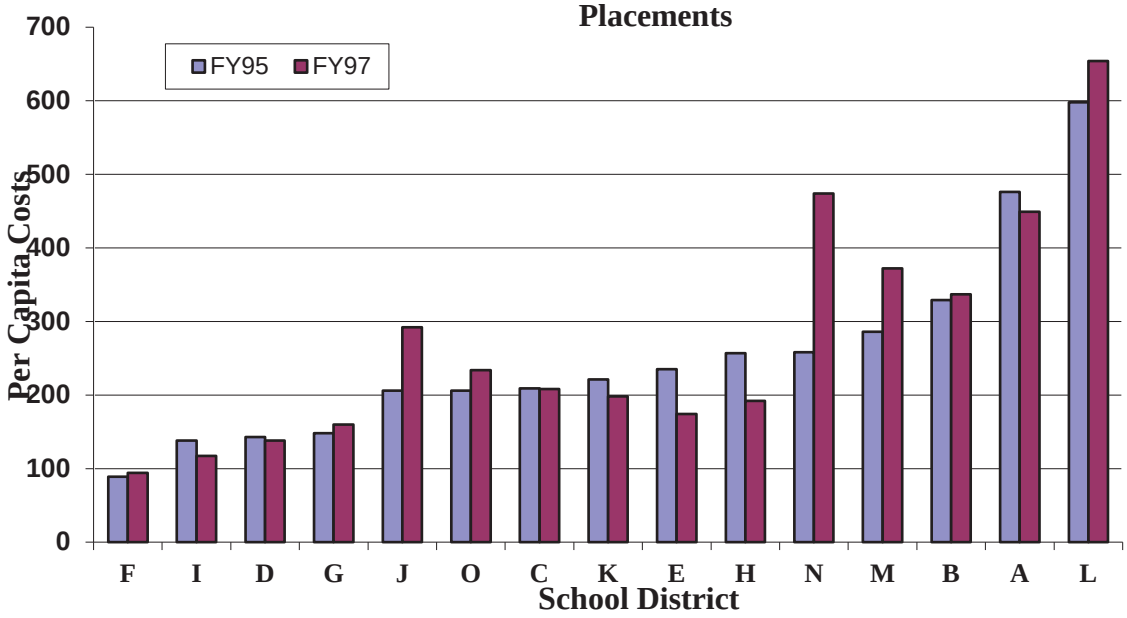
In a peer-reviewed retrospective study, we found that as a result of these efforts, this district (District F in Figures 15 and 16 below) had the highest rate of inclusionary services compared to 14 similar districts across the state.[145] Students with special needs in the target district received educational services in the regular classroom at a significantly higher rate than students in the other school districts. Furthermore, our analysis showed that the same district was spending less per capita on restrictive placements than the other comparable districts, funding that could then be redirected toward inclusive services. *See* Figure 16. By implementing effective inclusionary practices, the district served more students with EBD in regular classrooms and sent fewer students to restrictive settings outside the district.

**Figure 15: Comparison of Educational Services in the Regular Classroom by District**




[145] Robert Putnam et al., *Cost-Efficacy Analysis of Out-Of-District Special Education Placements: An Evaluative Measure of Behavior Support Intervention in Public Schools* (2002).

**Figure 16: School District's Per Capita Costs for Out of District Placements**




My experience working with this district and others to implement inclusionary services and supports that help students with behavior-related disabilities avoid restrictive placements is grounded in extensive research demonstrating not only the effectiveness of those services and supports, *see supra* at Part III, but also the strategies that can be used to achieve and sustain wide-scale reform.[146] To prevent unnecessary GNETS placements and serve more students with behavior-related disabilities in integrated classrooms, Georgia need not reinvent the wheel; the roadmap for reform is well-established. The successes I have witnessed at the district-level can be replicated statewide using the same proven strategies.[147] Indeed, Georgia is uniquely

[146] Denise Soares et al., *Practice-to-Research: responding to the complexities of inclusion for students with emotional and behavioral disorders with recommendations for schools*, 106 NASSP Bulletin 77-108 (2022); Martin Agran et al., *Why aren't students with severe disabilities being placed in general education classrooms: examining the relations among classroom placement, learner outcomes, and other factors*, 45 Research Practice Persons Severe Disabilities 4-13 (2020); Barbra Trader et al., *Promoting inclusion through evidence-based alternatives to restraint and seclusion*, 42 Research Practice Persons Severe Disabilities 75-88 (2017).

[147] School and Community Healing Collaborative (2023). A Pathway to Recovery and Resilience for our Children and Youth. Seattle: University of Washington School Mental Health Assessment, Research, and Training (UW SMART) Center.

positioned to leverage its existing systems to implement inclusionary practices and build inter-connected systems that will reach every school in the state.

### B. Leveraging Available Resources and Programs

There are substantial state and federal resources available to Georgia to support the expansion of programs for students with behavior-related disabilities. Through its Medicaid and PeachCare for Kids programs, Georgia already funds and administers key services that are effective in preventing unnecessary restrictive educational placement. Although the wide majority of students in GNETS are enrolled in Medicaid or PeachCare for Kids,[148] few of those students received Medicaid-reimbursable services in any meaningful amount before entering GNETS. *See supra* Part VII. This is a missed opportunity. Georgia could expand the amount of therapeutic Medicaid services it provides, reach significantly more students with behavior-related disabilities, and use federal funds to cover more than 65% of the cost.[149] The cost of services billed to Georgia's Medicaid program is borne in large part by the federal government, which matches every dollar the State spends at a rate of 1 to 1.93. In other words, for every dollar the State spends on qualifying services, the federal government matches that spending by $1.93.[150] By contrast, Georgia uses state-only funds for behavioral health services in GNETS facilities.

Georgia already bills Medicaid for school-based behavioral health services through the Apex Program; indeed, the State reported that in SY22 Medicaid and managed care accounted

[148] 81.8% of students in GNETS in SY 2020 and 81.4% of students in GNETS in SY2022 were enrolled in Medicaid or PeachCare for at least one quarter between SY 2016 and SY 2022.
[149] Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, KFF, *available at* https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, *last visited* June 11, 2023. *See* Holt et al., *Paths Toward Sustainable State and County Systems of Care*, 48 J. Behavioral Health Services Research 531-35 (2021).
[150] Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, KFF, *available at* https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D, *last visited* June 11, 2023.

for 84 percent of students receiving billable services through Apex.[151] By building on existing frameworks to maximize available Medicaid funding and expanding the provision of Medicaid services, the State can serve more students in their home schools rather than relying on unneccessary GNETS placements and can do so cost effectively.

In addition to the federal Medicaid match, Georgia can leverage other federal funding opportunities to support its expansion of integrated behavioral health services for students. Funding is available, for example, through SAMHSA's Community Mental Health Block Grant, which Georgia already receives annually, and through the Bipartisan Safer Communities Act ("BSCA").[152] In fact, Georgia's State School Superintendent Richard Woods committed to using certain federal allocations that the State receives to support student mental health programs.[153]

On top of these federal resources, Georgia has substantial state-source funds that it could deploy more effectively to support the expansion of integrated school-based behavioral health services. Most notably, in Fiscal Year 2023, Georgia allocated over $54 million in state funds to the GNETS Program, accounting for 88 percent of the total program budget.[154] By contrast, Georgia's total annual allocations for the statewide Apex Program are under $13.5 million.[155] Redirecting even a modest portion of its annual spending on the GNETS Program could help

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[151] GA05558501 Apex Year 7 Evaluation Slide Deck, page 23.
[152] *See* "Biden-Harris Administration Announces Nearly $100 Million in Continued Support for Mental Health and Student Wellness Through Bipartisan Safer Communities Act," U.S. Department of Education, *available at* https://www.ed.gov/news/press-releases/today-biden-harris-administration-announcing-more-95-million-awards-across-35-states-increase-access-school-based-mental-health-services-and-strengthen-pipeline-mental-health-professionals-high-needs-school-districts-t (last accessed 06/16/2023).
[153] "[i]n Georgia, we'll be using ARP funds to support student learning, address lost learning opportunities, ensure safe school environments, and expand resources and supports for student mental health and wellbeing. *See* www.ed.gov/news/press-releases/us-department-education-approves-georgias-plan-use-american-rescue-plan-funds-support-k-12-schools-and-students-distributes-remaining-14-billion-state, last accessed 05/06/2023)
[154] GaDOE December 2022 report to State Senate, GA05242582 at GA05242588.
[155] Separate from this annualized funding, Georgia allocated $8.4 million to the Apex Program during SY2020. Per DBHDD's website, that was a one-time, non-recurring allocation. https://dbhdd.georgia.gov/be-supported/mental-health-children-young-adults-and-families/apex-3-faqs.

Georgia significantly grow the reach of the Apex Program, which currently serves less than 34 percent of public schools in the state. *See supra* at Part VI.

## II. Providing Services Consistent with Established Standards Relating to Service Intensity, Early Identification, and PBIS

### A. Service Intensity

As discussed above, many students with behavior-related disabilities at serious risk of GNETS placement do not receive appropriate behavioral health services, or if they do, receive them only in limited amounts. *See supra* at Parts VI and VII. Georgia can take reasonable steps to ensure not only that its services are available in more integrated educational settings across the state, but also that those services are provided with sufficient intensity to meet students' needs, consistent with standards established by the State.

Specifically, Georgia can set expectations around behavioral health service delivery and student outcomes, including through its Apex and PBIS Programs, and can expand and enhance existing efforts to collect and analyze data in these areas. Georgia already collects some data on service utilization and educational and behavioral outcomes, but it is not effectively leveraging that reporting to assess whether students are receiving the right services in the right amount or whether the services are effective. *See supra* at Parts V, VI. Through enhanced monitoring and analysis, Georgia could also better assess whether service providers are incorporating evidence-based practices as appropriate and otherwise satisfying the quality standards established by the State, including in DBHDD's Provider Manual.

### B. Early Identification

Early identification of students who may need behavioral health services is important to improving outcomes for those students, including preventing unnecessary restrictive educational placements. Too often, however, students in Georgia receive either no services, inappropriate

services, or too few services before entering GNETS. The State can leverage existing data protocols, most notably those related to its PBIS Program, to facilitate the early identification of students with behavioral health needs and the prompt delivery of services in their home schools.

When implemented with fidelity, the PBIS model involves cross-disciplinary teams at each tier that regularly review exclusionary discipline data, attendance, and academic performance to identify students who may have unmet behavior-related needs. Sources available to these cross-disciplinary teams should include, in addition to the exclusionary discipline and other data regularly reviewed by such teams, parent and teacher referrals of students for behavioral health supports and the results of any behavioral health screenings.

### C. PBIS

A decade after Georgia initiated its PBIS Program, many schools in the state still have not implemented this important framework, which the State acknowledges is "proven to reduce disciplinary incidents, increase a school's sense of safety and support improved academic outcomes."[156] Furthermore, even schools in Georgia that do participate in PBIS often do not adhere to the evidence-based model. *See supra* at Parts IV, V. Georgia could reasonably expand and fully implement its existing PBIS Program to ensure the provision of timely, effective services to students with behavior-related disabilities. Despite the critical importance of Tier III supports and services, GaDOE has provided PBIS training only at Tiers I and II, and failed to provide training for the implementation of Tier III. Georgia could create the expectation that schools roll out PBIS, including Tier III, and provide training and support for Tier III. The State

[156] *See* Positive Behavioral Interventions and Supports, Georgia Department of Education, at https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Pages/Positive-Behavioral-Interventions-and-Support.aspx.

could further ensure system-wide access to appropriate data supports and providing effective training across all three service tiers.

**III. Effective Training and Technical Assistance**

Providing effective services for students with behavior-related disabilities requires that educators, school administrators, and service providers all have a baseline of knowledge, training, and experience consistent with established standards of care. Importantly, there are some services or assessments that school personnel may be able to provide if they have sufficient training in those interventions to do so. For example, a student's BIP may identify that they need certain interventions in the classroom in order to promote positive behaviors. The student's classroom teacher or aide must be effectively trained in order to implement that BIP and to help support the student in an integrated classroom setting. Further, Georgia can better meet the behavioral health needs of its students in integrated educational settings by expanding and enhancing its existing training and technical assistance programs for educational staff and school-based service providers, including those relating to evidence-based practices and PBIS. It is vital that the training and technical assistance available through the State be accurate, ongoing, and include follow-up supports to instill and reinforce key concepts.

**IV. Improving Coordination and Data Collection Across the System of Care**

Georgia has committed itself to building a comprehensive System of Care framework to better serve students with behavior-related disabilities in their own communities. Despite that commitment, key components of Georgia's System of Care—including Apex, PBIS, and Project AWARE—remain fragmented, undercutting their effectiveness in serving students at serious risk of restrictive educational placement. The State can address this by taking reasonable steps to fully implement the objectives set forth in its System of Care Plan, which include improving

coordination and data sharing between the State's child-serving agencies, local school districts, school-based service provider organizations, and other community partners.

As the State has acknowledged, effective coordination between State agencies and key stakeholders is "at the heart of the [System of Care] approach," allowing for more efficient use of limited resources, facilitating access to care, and creating accountability mechanisms to ensure that the State is meeting its objectives.[157] Cross-agency commitment to "effective and efficient spending" of available state and federal funds—including through the State's Medicaid program—is particularly important to supporting comprehensive school-based behavioral services that would divert more students from unnecessary GNETS placements.[158] Furthermore, by improving data sharing between key State agencies, Georgia can build its capacity to track and analyze student- and system-level outcomes, identify barriers to success, and drive program improvement—again, consistent with the State's own System of Care Plan.[159]

## CONCLUSION

The types of services, programs, and frameworks necessary to serve students with behavior-related disabilities in general education schools already exist in Georgia. Furthermore, Georgia has committed itself to ensuring access to a comprehensive, community-based System of Care for these children and their families. By building on and effectively leveraging its established services, programs, and frameworks, Georgia can advance this goal and divert

[157] Georgia System of Care Plan 2020, Exhibit 947, page 11, Monica Johnson Deposition, March 2, 2023.
[158] Georgia System of Care Plan 2020, Exhibit 947, page 11, Monica Johnson Deposition, March 2, 2023. *See also* Holt et al., *Paths Toward Sustainable State and County Systems of Care*, 48 J. Behavioral Health Services Research 531-35 (2021).
[159] Georgia System of Care Plan 2020, Exhibit 947, page 20, Monica Johnson Deposition, March 2, 2023. *See also* Holt et al., *Paths Toward Sustainable State and County Systems of Care*, 48 J. Behavioral Health Services Research 534 (2021).

students from unnecessary placement in restrictive educational settings like the GNETS Program.

## LIST OF APPENDICES

# APPENDIX A
# DR. ROBERT F. PUTNAM
# CURRICULUM VITAE

# VITA
# Robert F. Putnam

## PERSONAL INFORMATION


| | |
|---|---|
| Address: | The May Institute, Inc.<br>41 Pacella Park Drive<br>Randolph, MA 02368 |
| Business Telephone: | 617-365-6756 |
| Home Telephone: | 617-481-2782 |
| Date of Birth: | August 28, 1950 |
| Citizenship: | U.S. Citizen |
| Marital Status: | Married |


## EDUCATION

| | |
|---|---|
| Boston College | |
| Ph.D. Special Education and Rehabilitation | 1985 |
| Bridgewater State College | |
| M.Ed. Special Education | 1975 |
| Boston College | |
| B.S. Chemistry | 1972 |

## LICENSE & BOARD CERTIFICATIONS

Licensed Psychologist, Commonwealth of Massachusetts (License # 4143)
Health Care Service Provider
Board Certified Behavior Analyst – Doctoral (Certificant #1-03-1407)
Licensed Applied Behavior Analyst (License # 871-MH-B1)

## APPOINTMENTS

| | |
|---|---|
| Member, Massachusetts Statewide Advisory Committee, Positive Behavior Supports | 2022-present |
| International Consultant – United States Department of State | 2016-present |
| Chair, Mental Health and Positive Behavior support Ad Hoc Committee | 2020-present |
| Chair, Intellectual and Developmental Disabilities (IDD) Ad Hoc Committee | 2018-present |
| Past President Mass ABA | 2020-present |
| President Mass ABA | 2018-2020 |
| Member, Statewide Advisory Committee, Massachusetts Department of Developmental Services | 2016-present |
| President-Elect, Mass ABA | 2016-2018 |
| Board Member at Large | 2014-2016 |
| Treasurer and Member of Executive Council, Association for Positive Behavior Supports | 2014-2022 |
| Board Member, Association for Positive Behavior Supports | 2013-2022, 2023-2026 |
| Member, Executive Clinical Steering Committee, May Institute | 2010-present |
| Member, Regulations and Contract Subcommittee, Mass ABA | 2012-2013 |
| Member, Positive Behavior Support Subcommittee, Massachusetts Department of Development Disabilities | 2012-2015 |
| Member, Board of Professional and Technical Advisors, Autism Training | 2012-2015 |

| | |
|---|---|
| Solutions | |
| Board Member, Mass ABA | 2012-present |
| President, Positive Behavior Support Special Interest Group, Association of Behavior Analysis International | 2007-2012 |
| Associate Editor, Journal of Young and Intensive Behavior Interventions | 2008-2009 |
| Senior Vice President of Research and Consultation, National Autism Center | 2005-present |
| Expert Panelist, National Standards Project, National Autism Center | 2005-2007 |
| Consulting Editor, Journal of Positive Behavior Interventions | 2003-present |
| Editorial Review Board Member, The Journal of Behavior Analysis of Offender and Victim Treatment and Prevention | 2006-2007 |
| Associate Editor, Journal of Young and Intensive Behavior Interventions | 2008-2009 |
| Clinical Instructor, Harvard Medical School | 1995-2000 |
| Clinical Assistant Professor, Department of Counseling Psychology, Rehabilitation & Special Education, Bouve College of Pharmacy & Health Sciences, Northeastern University | 1999-2004 |
| Assistant Attending Psychologist, McLean Hospital | 1995 - 2000 |
| Member, Statewide Mental Health Planning Committee, Massachusetts Department of Mental Retardation | 1992 - 1998 |
| Member, Statewide Health and Habitation Services Advisory Committee, Massachusetts Department of Mental Retardation | 1992 - 1995 |
| State representative to the Association for Behavior Analysis, New England Society for Behavioral Analysis and Therapy | 1991 - 1992 |
| Member, Board of Directors, Berkshire Association for Behavioral Analysis and Therapy | 1990 - 1992<br>1997 - 2001 |
| Secretary and Treasurer, Berkshire Association for Behavioral Analysis and Therapy | 1992 - 1995 |
| Member, Board of Directors, New England Society for Behavioral Analysis and Therapy | 1989 - 1991 |
| Newsletter Editor, New England Society for Behavioral Analysis and Therapy | 1986 - 1989 |
| Member, Advisory Board, Multihandicapped Program, Boston College | 1986 - 1987 |
| Member, Board of Directors, Greater Fall River for Retarded Citizens | 1978 - 1979 |
| Vice-Chairman, Region VII Training and Education Council, Department of Mental Health | 1975 |
| Member, Board of Directors, Region VII Training and Education Council, Department of Mental Health | 1974 - 1975 |

**PROFESSIONAL EXPERIENCE**

May Institute
Executive Vice President of Positive Interventions and Supports & Consultation
Senior Vice President of Consultation 2014 – present

Responsible for implementing system-wide positive behavior interventions and supports across a multi-tier model across the Institute. This includes overseeing data systems, practices, and systems development and implementation. Provide consultation to numerous school districts in implementing district and school wide MTSS/PBIS. Direct research projects and grants in school-based interventions. Content expert for autism and developmental disabilities for the National Technical Assistance Center for Positive Behavior Interventions and Supports, funded by the Office of Special Education, U.S. Department of Education.

National Autism Center
Senior Vice President of Research and Consultation 2014-present
Director of Consultation 2005-2014

Oversee research and other projects within the National Autism Center. Participation in the development of and conducting of the National Standards Project.

May Institute
Senior Vice President of School Consultation 2003 – 2014

Oversee the clinical delivery of consultation and school support services to over 100 school districts in New England, the mid-Atlantic, and the southeastern United States. Overall clinical supervision of over 50 staff, post-doctoral fellows, and predoctoral interns in delivering these services. Provide consultation, program review, and school-wide interventions to school systems, emphasizing students with challenging behavior with various disabilities, including autism spectrum disorder, developmental disabilities, and behavioral disorders. Direct research projects and grants in school-based interventions. Direct the northeast National Technical Assistance Center for Positive Behavior Interventions and Supports funded by the Office of Special Education, U.S. Department of Education.

Vice President of Consultation and School Support Services 2000 – 2003

Oversee the delivery of consultation and school support services to over one hundred school districts within the Commonwealth of Massachusetts and numerous other states. Direct these services delivered from three programmatic sites within the Institute. Overall supervision of over 40 staff, post-doctoral fellows, and predoctoral interns in providing these services. Provided consultation to school systems to develop prevention services for students at risk of out of district placements. Developed a Positive Schools program, a comprehensive empirically-based school-wide program to improve schools' behavior climate and oversaw its implementation in eight different states.

Director of Consultation and School Support Services 1997 – 2000

Oversee the delivery of consultation and school support services to over one hundred school districts within the Commonwealth of Massachusetts and numerous other states. Provided consultation to school systems to develop prevention services for students at risk of out of district placements. Set standards for the delivery of these services. Provided supervision to staff, post-doctoral fellows, and interns in the delivery of these services. Developed Positive Schools program, a comprehensive empirically-based school-wide program to improve behavior climate in schools.

Vice President of Mental Health Services 1995 - 1997

Management of a variety of services to individuals with mental health needs. These include the delivery of outpatient, vocational, and other mental health services. Management of contracts to provide child and adolescent inpatient, residential and partial services at McLean Hospital and an inpatient unit and partial hospitalization program for adolescents at Somerville Hospital. Oversee the development of treatment protocols and utilization reviews for the service as well as internship training programs.

<u>Endicott College</u>

Serve as a doctoral advisor to seven doctoral candidates 2018 - present

<u>Cambridge College</u>

Serve as a dissertation advisor to one doctoral candidate 2021 - present

Brockton Public Schools 1988 - 2009
Consultant Behavioral Psychologist

Provide behavioral consultation to school personnel and parents concerning students of all ages with various special needs, including mental retardation, pervasive development disorder, autism, and emotional behavioral disorders. Provide in-service training to school personnel to improve effective educational services. Provide overall program evaluation of specific school programs.

South Shore Mental Health, Inc. 1984 - 1995
Director of Behavioral Services

Administration of a service unit within a nonprofit community mental health center, serving over 500 individuals with various disabilities in a range of services with an operating budget of over 12 million. These include residential services for more than 215 persons with chronic and persistent mental illness, mental retardation, or autism. Other services include crisis intervention, outpatient, day habilitation, case management, respite, and supported employment. Supervise a staff of over 350, including over 30 Master level, 12 Ph.D., and 3 M.D. level personnel. Expanded services from less than 1 million to over 12 million. Developed mobile community-based crisis intervention and stabilization services, including an affiliation with a private psychiatric hospital to co-manage a psychiatric unit for individuals with developmental disabilities. Developed a behavioral, clinical APA-approved predoctoral internship program tract. Oversaw CARF accreditation for the agency-accredited programs. Developed staff performance and program evaluation system. Serve on Executive Committee. Served as chairperson of the Human Rights Committee.

Assistant Director, Developmental Services 1983 - 1984

Provided administrative and clinical supervision to day habilitation and respite care programs serving over 70 individuals with mental retardation and employing over 35 professional and paraprofessional staff. Provided individual therapy to individuals with various mental health needs. Served as a member of the agency's Human Rights Committee.

Behavioral Psychologist 1983

Provided consultation to staff within a day habilitation program. Developed and implemented individual and group behavioral programs to improve social skills.

Private Practice 1986 - 2009

Private practice emphasizing behavioral assessment and therapy with individuals with stress-related disorders, behavioral and interpersonal problems. Specialization in individuals with challenging behavior and psychiatric issues.

Southeast Human Resources 1987 - 1988
Behavioral Psychologist

Provided supervision and consultation to programs and staff serving behaviorally challenged individuals.

Coastal Community Counseling Center 1983 - 1988
Behavioral Psychologist

Provided outpatient psychological services to individuals with mental retardation, including individual and family behavioral therapy, relaxation therapy, biofeedback, and intellectual and behavioral assessments. Provided behavioral consultation to schools and other agencies serving these individuals.

Greater Lawrence Psychological Center 1983 - 1984
Behavioral Psychologist

Provided individual behavioral therapy to individuals with mental retardation within a community setting. Provided consultation to staff concerning these individuals.

Telesis Academy 1981 - 1983
Special Education Administrator
Founder and educational coordinator for a behavioral-educational residential program for special needs children and adolescents.

Crystal Springs School 1975 - 1981
Special Educator Administrator
Provided administrative and clinical supervision to a residential and day program serving over 100 special needs individuals. Provided staff training in the areas of behavior therapy and applied behavioral analysis procedures. Served as Chairperson of Human Rights Committee.

Paul A. Dever State School 1972 - 1975
Director of the Blind Unit 1974 - 1975
Initiated the first educational program and a separate behavioral-residential unit for individuals with sensory impairments and severe or profound mental retardation.

Day Care Developmental Specialist 1973 - 1974
Provided instruction to individuals with mental retardation and sensory impairments

Special Service Assistant 1972 - 1973
Assisted behavioral psychologist in the provision of programming to individuals with mental retardation.

**GRANTS**

Principal Investigator, May Institute, School-wide Positive Behavior Interventions & Supports. University of Connecticut and Massachusetts Department of Elementary and Secondary Education. July 2018 - 2021 ($699,578)

Principal Investigator, May Institute, Meaningful Jobs funded by the Kessler Foundation, January 2017 – 2019. ($250,000)

Partner, May Institute, Center for Positive Behavior Behavioral Interventions and Supports, funded by the U.S. Department of Education, Grant # H326S030002 October 2018 – 2023 ($550,000).

Partner, May Institute, Center for Positive Behavior Behavioral Interventions and Supports, funded by the U.S. Department of Education, Grant # H326S030002 October 2013 – 2018 ($50,000).

Partner, May Institute, Center for Positive Behavior Behavioral Interventions and Supports, funded by the U.S. Department of Education, Grant # H326S030002 October 2008 – 2013 ($50,000).

Partner, May Institute, Center for Positive Behavior Behavioral Interventions and Supports, funded by the U.S. Department of Education, Grant # H326S030002 October 2003 – 2008 ($300,000).

Co-principal Investigator, May Institute, The Trenton Positive School System Initiative, funded by the Geraldine Dodge Foundation, May 2003- April 2004 ($25,000).

**PUBLICATIONS**

Maki, E., Shaw, S., Putnam, R., Harrington, E., Schrieber, S. (2022). Supporting Students with Autism Spectrum Disorders Through School-Wide Positive Behavior Interventions and Supports. Center on PBIS, University of Oregon. www.pbis.org.

Barby, S., Gerhardt, P., Weiss, M.J., Leaf, J., Putnam, R., & Bondy, A. (2022). The Ethics of Actually Helping People: Targeting Skill Acquisition Goals That Promote Meaningful Outcomes for Individuals with Autism Spectrum Disorder. Behavior Analysis in Practice.

Smilak, N. & Putnam, R. (2022). A Critique of Colonialism and Modern Aid in Africa: What Would Skinner Say? in Behavior and Social Issues special issue on Revitalizing Behavioral Community Psychology. 252-273.

Strickland-Cohen, K., Newson, A., Myer, K., Putnam, R., Kern, L., Myer, B., & Flammini, E. Strategies for De-escalating Student Behavior. (2022)**.** Eugene, OR: Center on PBIS, University of Oregon. www.pbis.org.

Kern, L., Simonsen, B., George, H. P., Robbie, K., & Putnam, B. (2021). Questions for Families to Consider when Concerned about their Child's Behavior. Center on PBIS, University of Oregon. www.pbis.org

Meyer, K., Sears, S., Putnam, R., Phelan, C., Burnett, A., Warden, S., & Simonsen, B. (2021). Supporting Students With Disabilities With Positive Behavioral Interventions and Supports in the Classroom: Lessons Learned From Research and Practice. *Beyond Behavior*. https://doi.org/10.1177/10742956211021801

Simonsen, B., Putnam, R., Yaneck, K., Evanovich, L., Shaw, S. Shuttleton, C. Morris, K., & Mitchell, B. (2020). *Supporting students with disabilities within a PBIS framework.* Center on PBIS, University of Oregon. www.pbis.org.

Eber, L., Barrett, S., Perales, K., Jeffrey-Pearsall, J., Pohlman, K., Putnam, R, Splett, J., & Weist, M.D. (2019). *Advancing Education Effectiveness: Interconnecting School Mental Health and School-Wide PBIS, Volume 2: An Implementation Guide*. Center for Positive Behavior Interventions and Supports (funded by the Office of Special Education Programs, U.S. Department of Education). Eugene, Oregon: University of Oregon Press.

Horner, R.H., Ward, C. S., Fixsen, D.L., Sugai, G., McIntosh, K., Putnam, R., & Little, H.D. (2019). Resource leveraging to achieve large-scale implementation of effective educational practices. *Journal of Positive Behavior Interventions. 21(2).* 1–10. DOI 10.1177/1098300718783754.

Simonsen, B., Freeman J., Swain-Bradway, J., Peshak George, H., Putnam. R., Lane, K.L., Sprague, J., & Hershfeldt, P. (2019). Using data to support educators' implementation of positive classroom behavior support (PCBS) practices. *Education and Treatment of Children, 42(2)* 265-290.

Weist, M., Horner, R., Splett, J., Eber, L., Putnam, R., Barrett, S., Perales, K., Fairchild, A.J. & Hoover, S. S. (2018). Improving multi-tiered systems of support for students with "internalizing" emotional/behavioral problems. *Journal of Positive Behavior Interventions. (20).* 172- 184.

Swain-Bradway, J., Putnam, R., Freeman, J., Simonsen, B., George, H. P., Goodman, S., Yanek, K., Lane, K. L. & Sprague, J. (2017). PBIS technical guide on classroom data: Using data to support the

implementation of positive classroom behavior support practices and systems. Eugene, OR: National Technical Assistance Center on Positive Behavior Interventions and Support.

Freeman, J., Simonsen, B., Goodman, S., Mitchell, B., George, H. P., Swain-Bradway, J., Lane, K., Sprague, J., & Putnam, B. (2017). PBIS technical brief on systems to support teachers' implementation of positive classroom behavior support. Eugene, OR: PBIS Center.

Putnam, R.F. & Knoster, T. (2016). A Reply to the Commentaries on School-wide PBIS: An Example of Applied Behavior Analysis Implemented at a Scale of Social Importance by Horner and Sugai (2015): PBIS is Function over Form: The Clear Behavioral Roots and Opportunities the PBIS Framework presents to the Field of Behavior Analysis Moving Forward. *Behavior Analysis in Practice*, 9, 95-101.

Simonsen, B., Freeman, J., Goodman, S. Mitchell, B., Swain-Bradway, J., Flannery, B. Sugai, G., George, H. & Putman, R. (2015). Supporting and Responding to Behavior: Evidence-Based Classroom Strategies for Teachers. www.pbis.org.

Simonsen, B., Freeman, J., Goodman, S. Mitchell, B., Swain-Bradway, J., Flannery, B. Sugai, G., George, H. & Putman, R. (2015). Supporting and Responding to Behavior: Evidence-Based Classroom Strategies for Teachers. U.S. Department of Education. Office of Special Education Programs. https://osepideasthatwork.org/evidencebasedclassroomstrategies/

Putnam, R. F., & Kincaid, D. (2015). School-wide PBIS: extending the impact of applied behavior analysis: why is this important to behavior analysts? *Behavior Analysis in Practice*, *8*, 88–91.

Barry, S., Putnam, R., Splett, J., & Weist, M. (2015). Interconnected Systems Framework (ISF): PBIS Forum in Brief. www.pbis.org.

Algozzine, B., Barrett, S., Eber, L., George, H., Horner, R., Lewis, T., Putnam, B., Swain-Bradway, J., McIntosh, K., & Sugai, G (2014). School-wide PBIS Tiered Fidelity Inventory. OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports. www.pbis.org.

Putnam, R., & Goodman, S. (2014). Positive Behavior Support, Urban Settings. In Reynolds, C.R., Vannest, K.V. & Fletcher-Janzen, E. *Encyclopedia of Special Education, A Reference for the Education of Children, Adolescents, and Adults Disabilities and Other Exceptional Individuals. 4th Ed.*

Lever, N. & Putnam R. (2014). The role of school level systems in interconnecting school mental health and school-wide positive behavior support. in Barrett, S., Eber, L. & Weist. (ed). *Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support.* www.pbis.org.

Putnam, R., Barrett, S., Eber, L., Lewis, T. & Sugai. G. (2014). Selecting mental health interventions within a PBIS approach. *Advancing Education Effectiveness: Interconnecting School Mental Health and School-wide Positive Behavior Support.* www.pbis.org.

Algozzine, R., Putnam, R., & Horner, R. (2012). Support for teaching students with learning disabilities academic skills and social behaviors within a response-to-intervention model: Why it does not matter what comes first. *Insights on Learning Disabilities 9(1),* 7-36.

Hauser, M. J., Putnam, R.F., & Young, G.I. (2011). Education and habilitation. In Drogin, E.Y., Dattilio, F.M., Sadoff, R.L., & Gutheil, T.G. *Handbook of Forensic Assessment: Psychological and Psychiatric Perspectives.* Hoboken, New Jersey. John Wiley & Sons. 417-432.

Sugai, G., Horner, R.H., Algozzine, R., Barrett, S., Lewis, T., Anderson, C., Bradley, R., Choi, J. H., Dunlap, G., Eber, L., George, H., Kincaid, D., McCart, A., Nelson, M., Newcomer, L., Putnam, R., Riffel, L., Rovins, M., Sailor, W., Simonsen, B. (2010). *School-wide positive behavior support: Implementers' blueprint and self-assessment*. Eugene, OR: University of Oregon.

Algozzine, B., Putnam, R., & Horner, R. (2010). What we know about the relationship between achievement and behavior. In B. Algozzine, A. P. Daunic, & S. W. Smith (Eds.), *Preventing problem behaviors* (2nd ed.) (pp. 223-226). Thousand Oaks, CA: Corwin.

Putnam, R.F., McCart, A., Griggs, P., & Hoon Choi, J., (2009). Implementation of school-wide positive behavior support in urban settings. in Sailor, W., Dunlap, D., Sugai, G., & Horner, R. *Handbook of Positive Behavior Support.* New York: Springer. 443-463.

Putnam R.F., and Handler, M.H. *Rules and procedures*. (2009). in Anderman, E. & Anderman, L. (ed.). *Psychology of Classroom Learning: An Encyclopedia*, Detroit: Macmillan Reference. 170-173.

Putnam, R., Romano, S., Agorastou, M., Baker, E., Irvin, L., O'Connell, D., Screiner, S., &Stone, L., (2009). Establishing and maintaining staff participation in PBIS high schools. In B. Flannery & G. Sugai (Eds.), *SWPBS implementation in high schools: Current practice and future directions.* (pp. 43-56). University of Oregon.

Algozzine, B., Horner, R., & Putnam, R. (2008). Which came first: The achievement or the behavior problem. Charlotte, NC: Behavior and Reading Improvement Center

Putnam, R.F., Horner, R.F., & Algozzine, R. (2007). Academic achievement and the implementation of school-wide behavior support. www.pbis.org/pbis_newsletter/volume_3/issue1.aspx. 3(1). 1-3.

Handler, M., Rey, J., Connell, J., Their, T., Feinberg, A. & Putnam R. (2006). Practical considerations in creating school-wide positive behavior support in public schools. *Psychology in the Schools. 44(1),* 29-39.

Luiselli, J. K., McCarty, J. C., Coniglio, J., Zorilla-Ramirez, C., & Putnam, R. F. (2005). Social skills assessment and intervention: Review and recommendations for school practitioners. *Journal of Applied School Psychology, 21,* 21-38.

Luiselli, J.K., Putnam, R.F., Handler, M.W., & Feinberg, A. (2005). Whole-school positive behavior support: Effects on student discipline problems and academic performance. *Educational Psychology, 25(2-3),* 183-198.

Putnam, R.F., & Hehl, D.H. (2005). Development and Enhancement of school-wide high school teams. In Bohanon-Edmonson, H., Flannery, K. B. Eber, L. & Sugai, G. Positive Behavior Support in High Schools: Monograph from the 2004 Illinois High School Forum of Positive Behavioral Interventions and Supports. http://www.pbis.org/common/pbisresources/publications/PBSMonographComplete.pdf. (16-24).

Putnam, R.F. Handler, M.W., & Luiselli, J.K. (2004). Positive Schools: An approach to school discipline. *Psychiatric Services, 54,*1039.

Putnam, R.F., Handler, M.W., Ramirez-Platt, C.M. & Luiselli, J.K. (2004) Improving student bus riding behavior through a Whole-School Intervention. *Journal of Applied Behavior Analysis*. 36, 583-590.

Putnam, R.F., Handler, M. W., Rey, J., & McCarty, J. (2003). The development of behaviorally based public school consultation services. *Behavior Modification. 27,* 505-523.

Putnam, R.F., Luiselli, J.K., Handler, M.W. & Jefferson, G.L. (2003). Evaluating student discipline practices in a public school through behavioral assessment of office referrals. *Behavior Modification, 27,* 505-523.

Jefferson, G.L., & Putnam, R.F. (2002). Understanding transition services: A parent's guide to legal standards and effective practices. *Exceptional Parent Magazine, 32,* 70-77.

Rey, J. & Putnam R. (2002). Effective social skills programming. *Exceptional Parent Magazine, 32,* 32-37.

Putnam, R.F., Luiselli, J.K. & Sunderland, M. (2002). Longitudinal evaluation of behavior support intervention in a public middle school. *Journal of Positive Behavior Interventions. 4,* 182-188.

Putnam, R.F., Luiselli, J.K., Sennett, K. & Malonson, J. (2002). Cost-efficacy analysis of out-of-district special education placements: An evaluative measure of behavior support intervention in public schools. *Journal of Special Education Leadership, 15,* 17-24.

Putnam, R.F., Luiselli, J.K. & Jefferson, G.L. (2002). Expanding technical assistance consultation to public schools: District-wide evaluation of instructional and behavior support practices for students with developmental disabilities. *Child & Family Behavior Therapy, 24,* 113-128.

Luiselli, J.K., Putnam, R.F. & Handler, M.W. (2001) Improving discipline practices in public schools: Description of a whole-school and district-wide model of behavior analysis consultation. *The Behavior Analyst Today, 2*, 18-26.

Putnam, R.F. (1999). Designing effective school-wide discipline strategies, *Massachusetts School Psychologists Association Newsletter, 20*, 1-3.

Luiselli, J.K. Bastien, J.S. & Putnam, R.F. (1998). Behavioral assessment and analysis of mechanical restraint utilization on a psychiatric child and adolescent inpatient setting. *Behavioral Interventions*, *13*, 147-155.

Putnam, R.F., Apolito, P.M., Harris, J.M., Hirsh, M.J., Shannon, D.M., and O'Meara, R. (1989). The development of a regional community crisis team for individuals with mental retardation, *The Behavior Specialist, 1*, 1-3.

Neill, J.C., Alvarez, N., & Putnam, R.F. (1989). EMG conditioning in mentally retarded and/or multiply handicapped individuals. Invited chapter in J. Mulick and R. Antonak (Eds.), *Transitions in mental retardation, Volume 4*. Ablex Press. 347-354.

## TEACHING EXPERIENCE

| | |
|---|---|
| Endicott College | |
| Doctoral Advisor | 2016-current |
| Boston College | 1983 |
| Adjunct Lecturer | |
| Behavioral Management of Severe Special Needs Individuals. | |
| Invited Speaker in Behavioral Management Courses | |
| Boston College (1979,1980,1982) | |
| Bridgewater State College (1975,1976,1977,1978) | |
| Cape Cod Community College (1981) | |
| Boston Architectural Center | 1974 |
| Assisted in Design for the Handicapped Course | |

## MEMBERSHIP IN PROFESSIONAL SOCIETIES AND ORGANIZATIONS

| | |
|---|---|
| Mass ABA | 2012-present |
| Association for Positive Behavior Supports | 2005-present |
| American Psychological Association | 1985-present |
| Massachusetts Psychological Association | 1988-1993 |
| Association for Behavior Analysis International | 1985-present |
| Berkshire Association for Behavioral Analysis and Therapy | 1985-present |
| New England Biofeedback Society | 1984-1985 |
| Massachusetts Biofeedback Society | 1983-1986 |
| New England Society for Behavioral Analysis and Therapy | 1982-2001 |
| The Association for Severely Handicapped | 1980-1990 |
| American Association of Mental Retardation | 1974-1993 |
| Council for Exceptional Children | 1974-2003 |

## CONFERENCE SESSIONS, PRESENTATIONS, AND INVITED ADDRESSES

Yanek, K. & Putnam, R.F. (June, 2023). Improving Classroom Systems. [Invited webinar session]. National Technical Assistance Center for Positive Behavior Interventions and Supports.

Putnam, R. (June 2023). *Improving Equity in Schools*. (Invited webinar session). Improving Diversity, Equity & Inclusion Conference. Endicott College. Beverly, MA.

Putnam, R.F., & St. Joseph, S. (May, 2023). Effective Recognition Systems: PBIS Recognition focused on student outcomes [Invited webinar session]. National Technical Assistance Center for Positive Behavior Interventions and Supports.

Putnam, R. (May, 2023). *How BCBAs Can Improve Classroom Management Practices?* [Invited webinar session]. Mass ABA Conference.

Robertson, F., Putnam, R. & Casavant, A. (May, 2023). *Improving Mental Health Outcomes - Interconnected Systems Framework – Aligning SEL/Mental Health with MTSS.* Northeast PBIS Network Leadership Forum. Mystic, CT.

Putnam R. & Casavant, A. (April, 2023). *Improving Mental Health Outcomes - Interconnected Systems Framework – Aligning SEL/Mental Health with MTSS.* Southeastern School Behavioral Health Conference. Myrtle Beach, SC.

Putnam, R., George, J., De Pasquale, M., Harris, L. & Jeffrey-Pearsall, J. (March, 2023). *Establishing State-wide Policies and Procedures for PBS in the IDD Field.* [Session]. Association for Positive Behavior Support, Jacksonville, FL.

St. Joseph, S. & Putnam, R. (March, 2023). *Using Evidence-based Interventions for Students and Staff for Anxiety and Stress across the tiers.* [Session]. Association for Positive Behavior Support. Jacksonville, FL.
Strickland-Cohen, K., Connolly, K, St. Joseph, S. & Putnam, R. (March, 2023). *Improving the Effectiveness and Efficiency of Tier 3 Systems.* [Session]. Association for Positive Behavior Support, Jacksonville, FL.

Putnam, R. (March, 2023) *Positive Behavior Interventions and Supports: Why is This Important to Families & Staff?* [Invited webinar]. Mass ARC.

Putnam, R., George, J. & Miller, C. (November, 2022). *Implementing PBIS Support with Individuals with IDD: Implementing Massachusetts DDS Positive Support Regulations*. [Presentation]. New England Positive Behavior Interventions and Support Conference. Norwood. MA.

Putnam, R., Roberts, R. & Green, J. (November, 2022). *Implementing PBS Support with Individuals with IDD.* [Presentation]. New England Positive Behavior Interventions and Support Conference. Norwood. MA.

Putnam, R. (November, 2022). *Strategies for De-escalating Behavior.* [Presentation]. New England Positive Behavior Interventions and Support Conference. Norwood. MA.

Putnam, R. & Casavant, A. (October, 2022). *Planning for Teaching & Learning for All Students, with a Focus on Students with Disabilities.* [Invited]. National Positive Behavior Interventions and Support Leadership Conference. Chicago, IL.

Putnam, R. & Conley, K. (October, 2022). *District & school implementation of Tier 3 supports.* [Invited]. National Positive Behavior Interventions and Support Leadership Conference. Chicago, IL.

Similak, N, Wasserman, D. & Putnam. (September, 2022). *Applied Behavior Analysis: The potential for improving international societal problems.* [Symposium]. Association for Behavior Analysis International Annual Convention, Dublin, Ireland.

Putnam, R., Casavant, A. West, J. & Goguen, K. (September, 2022). *Using Applied Behavior Analytic interventions within a multi-tiered framework to improve student outcomes.* [Symposium]. Association for Behavior Analysis International Annual Convention, Dublin, Ireland.

Putnam, R. & Maki, E. (May, 2022). *Improving positive classroom behavior support through applied behavior analysis.* [Workshop]. Association for Behavior Analysis International Annual Convention, Boston, MA.

Putnam. R., Casavant, A., Robertson, F. & West, J. (May, 2022). *Implementing applied behavior analytic classroom practices to improve academic engagement.* [Symposium]. Association for Behavior Analysis International Annual Convention. Boston, MA.

Putnam, R., Weber, J.J., Mason, B.K., & Lord, J.A.. (May, 2022). *What works to reduce bullying from applied behavior analytic perspective?* [Symposium]. Association for Behavior Analysis International Annual Convention. Boston, MA.

Putnam, R. & Casavant, A. (May, 2022). *Improving the Effectiveness of Behavior Support Practices Across the Tiers*. [Invited webinar]. Accept Collaborative Public Schools BCBA Group.

Putnam, R., Pellegrino, M., Casavant, A.& West., J. (April, 2022). *Attending to Attendance: Improving Attendance through MTSS in a Live and Virtual World* [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA

Lariviere, A., Maki, E., & Putnam, R. *(*April, 2022*). The Use of High-leverage Evidence-Based Classroom Practices to Improve Academic Engagement*. [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA

Jeffries-Pearsall, J., Shear S., & Putnam, R. (April, 2022). *Organizing PBS in Organizations Supporting People With IDD.* [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA

Jeffrey-Pearsall, J., DePasquale, M., Putnam, R., Evans, R. (April, 2022). *Statewide Infrastructure for PBS in Adult Supporting Organizations: Maryland, Massachusetts, & Missouri.* [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA

Putnam, R., Downs, C., Pellegrino, M., Casavant, A., & West, J. *(*April, 2022). *Attending to Attendance: Improving Attendance Through MTSS in Live and Virtual Settings.* [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA

Pellegrino, M., Casavant. A., West, J. & Putnam, R. *(*April, 2022*). Strategically Leveraging Building Leaders to Foster Adaptive Change in a District-wide MTSS Initiative -- Lessons Learned.* [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA.

West, J., Putnam. R., Downs, C., Casavant, A., & Pellegrino, M., (April, 2022). *Improving Mental Health Outcomes Interconnected Systems Framework: Aligning SEL/Mental Health & MTSS.* [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA.

Sasaki Solis, M., Putnam, R. & Downs C. (April, 2022). *Trauma-Informed Behavior Interventions.* [Presentation]. Association for Positive Behavior Support Conference. San Diego. CA.

Putnam, R. & Sasaki Solis, M., (March, 2022). *Improving Classroom Behavior Support through Applied Behavior Analysis.* [Workshop]. California Association for Applied Behavior Association Conference. Santa Clara, CA.

George, J. & Putnam, R. *(*2021, November). *Implementing PBS support with individuals with IDD: Implementing Massachusetts DDS Positive Support Regulations.* [Presentation]. New England Positive Behavior Interventions and Support Conference. Norwood. MA.

Putnam, R., Shear, S. & Jeffrey-Pearsall, J. (2021, November). *Developing and implementing PBIS for adults with IDD from both state and organizational perspectives.* [Presentation]. at the New England Positive Behavior Interventions and Support Conference. Norwood. MA.

Putnam, R., Pellegrino, M., Casavant A., & West, J. (2021, October). *Improving attendance across live & virtual settings.* [Invited session]. National Positive Behavior Interventions and Support Leadership Conference. Chicago, IL.

Eber, L., Putnam, R. & McCrillis. K. (2021, October). *School-level implementation of the interconnected systems framework: Where the rubber meets the road.* [Invited session]. National Positive Behavior Interventions and Support Leadership Conference. Chicago, IL.

Putnam, R., Simonsen, B., & Casavant, A. (2021, October). *Implementing the continuum in the classroom to support each & every learner.* [Invited session]. at the National Positive Behavior Interventions and Support Leadership Conference. Chicago, IL.

Sasaki Solis, M. & Putnam, R. (2021, October). *Trauma-Informed behavior interventions.* [Presentation]. California PBS Conference. San Jose, CA.

Putnam. R. (2021, September). *Benefits of providing behavioral supports and emotionally supportive environments for students returning to school.* [Invited panelist]. U.S. Department of Justice & Office of Civil Rights. Webinar.

Putnam, R, Maki, E & Shaw. S. (2021). *Improving positive classroom behavior support through applied behavior analysis.* [Workshop]. Association for Behavior Analysis International Annual Convention.

Putnam R. (2021). *Tier 2 (targeted) prevention interventions.* [Presentation]. Gardner Public Schools. Gardner, MA. United States.

Putnam, R. (2021). *Improving student engagement, teacher student relationships, teacher efficacy, and academic achievement by improving classwide instruction and behavior support.* [Presentation]. Gardner Public Schools. Gardner, MA. United States.

Putnam, R. & Maki E. (2020). *Improving attendance through a multitiered system of support.* New Bedford Public Schools. New Bedford, MA. United States.

Putnam, R., Zarcone. J, Weddle, S, Riccardi, J., & Worcester, J. (2020). *Implementing PBS support with individuals with IDD across two organizations.* [Conference session]. New England PBIS Forum. Randolph, MA. United States

Putnam, R., West, J. Casavant, A. DeLuca, S., & Verge, J. (2020). *Implementing district-wide PBIS.* [Conference session]. New England PBIS Forum. Randolph, MA. United States

Putnam, R, Maki, E., & Shaw, S. (2020). *Improving positive classroom behavior support through applied behavior analysis.* [Workshop]. Association for Behavior Analysis International Annual Convention, Chicago, IL

Putnam, R. & Maki, E. (2020). *PBIS training for coaches.* [Presentation Series]. Milton Public Schools. Milton, MA. United States.

Putnam, R.F. (2020). *Introduction to improving classroom behavior support.* [Presentation]. Gardner Public Schools. Gardner, MA. United States.

Putnam, R.F. (2020). *Improving classroom behavior support.* [Training series]. New Bedford Public Schools. New Bedford, MA. United States.

Putnam R.F & Martin, D. (2019). *Improving classroom behavior support*. [Presentation]. Worcester Public Schools. Randolph, MA. United States.

Putnam, R, Maki, E & Kleinert. W. (2019). *Improving positive classroom behavior support through applied behavior analysis*. [Workshop]. Association for Behavior Analysis International 46th Annual Convention, Chicago, IL. United States.

Iovannone, R., Putnam, R., Greenwald, A., & Soracco, J. (2019). *Impact of school-wide positive behavioral interventions and supports (SWPBIS) and applied behavior analysis (ABA) on educational systems*. [Conference session]. Association for Behavior Analysis International 45th Annual Convention, Chicago, IL United States.

Putnam, R. & Myers, K. (2019). *PBIS 101: What the heck is SWPBIS?* [Presentation]. Lynn Public Schools, Lynn, MA. United States

Putnam, R., & Everett, S. (2019). *Data based decision making with students with disabilities at all three tiers*. [Conference session]. Northeast Positive Behavior Interventions & Supports, Mystic, CT. United States.

Putnam, R. (2019). *School-wide PBIS and autism*. (Invited Webinar). Clinical Coordinating Center for the Autism Speaks Autism Treatment Network/Autism Intervention Research Network on Physical Health, Boston, MA. United States

Downs, C. & Putnam, R. (2019). *Beyond data collection: Using data to make a difference in IDD settings.* [Conference session]. International Conference for the Association for Positive Behavior Support, Washington, DC. United States.

Simonsen, B, Putnam, R., & Sears, S. (2019). *Supporting students with disabilities within a PBIS framework*. [Conference session]. National PBIS Leadership Forum, Chicago, IL. United States

Putnam, R., Smith, S., Shaw, C., & Fontechia, S. (2019). *Innovative practices in vocational services for individuals with IDD or ASD*. [Invited conference session]. International Conference for the Association for Positive Behavior Support, Washington, DC. United States.

Putnam, R., Conley, K., Kittleman, A., & Sandomierski, T. (2019). *Tier III progress monitoring; Can individualized supports be monitoring systematically, efficiently, & individually?* [Conference session]. PBIS National Forum, Chicago, Ill. United States.

Putnam, R., & Weiner, B. (2019). *Using PBIS to support students with autism in general education classroom: Strategies for coaches.* [Conference session]. PBIS National Forum, Chicago, Ill. United States.

Simonsen, B., Putnam, R. & Young, D. (2019). *Supporting students with disabilities in the classroom with PBIS*. [Conference session]. PBIS National Forum, Chicago, Ill. United States.

Putnam, R., & Kleinert, W. (2019). *Improving classroom behavior support through applied behavior analysis*. [Conference session]. Massachusetts Association for Behavior Analysis, Westboro, MA. United States.

Putnam, R, & Kleinert. W. (2019). *Improving positive classroom behavior support through applied behavior analysis.* [Workshop]. Association for Behavior Analysis International 45th Annual Convention, Chicago, IL United States.

Putnam, R. & Maki, E. (2019). *PBIS training for coaches*. (Presentation Series). Milton Public Schools. Milton, MA. United States.

Putnam, R., Sprague, J., Clemons, K, & Casella D., (2018). *Implementing PBIS in alternative settings.* [Conference session]. PBIS National Forum, Chicago, Ill. United States.

Conley, K., Kittleman, A., Sandomierski, T., Putnam, R. & Ingram, K. (2018*). Tier III progress monitoring; Can individualized supports be monitoring systematically, efficiently, & individually?* We think so! [Conference session]. PBIS National Forum, Chicago, Ill. United States.

Putnam, R. (2018). *Multi-tiered Systems of Support: AKA PBIS: What is the role of behavior analysts?* [Conference session]. Massachusetts Association for Behavior Analysis, Westboro, MA. United States.

Putnam, R.F. (2018). *Improving prosocial behavior and reducing problematic behavior.* [Presentation series]. Santa Clara Department of Education. Sant Clara, CA. United States.

Meyers, K, & Putnam, R. (2018). *Classroom behavior supports.* [Presentation]. Lynn Public Schools. Lynn Public Schools. Lynn, MA. United States.

Putnam, R. & Sperry, R. (2018). *Oman autism training program.* [Training institute]. The national government of Oman. Doha, Oman.

Putnam, R. & Sperry, R. (2018). *Oman autism training program.* [Training institute]. The national government of Oman. Shaffalah, Oman.

Putnam, R. & Sperry, R. (2017). *Oman autism training program.* [Training institute]. The national government of Oman. Muscat, Oman.

Putnam, R. & Sperry, R. (2017). *Oman autism training program.* [Training institute]. The national government of Oman. Shaffalah, Oman.

Freeman, R. & Putnam, R. (2017). *Two different models for implementing PBS in organizations supporting people with disabilities.* [Conference session]. International Conference on Positive Behavior Support, Chicago, Ill. United States.

Putnam, R., Barry, S & Rossi, C. (2017). *Implementing positive behavior support within an organization serving individuals with ASD and IDD.* [Conference session]. International Conference on Positive Behavior Support, Chicago, Ill. United States.

Putnam, R. (2017). *Scaling up applied behavior analysis: Implementing multi-tiered systems of support in schools and other organizations.* [Conference session]. Association for Behavior Analysis International Annual Convention, Chicago, IL. United States.

Putnam, R & Barry, S. (2017). *Improving the effectiveness of tier 2 interventions.* [Conference session]. International Conference on Positive Behavior Support, Chicago, Ill. United States.

Freeman, R. & Putnam, R. (2017). *Two different models for implementing PBS in organizations supporting people with disabilities.* [Conference session]. International Conference on Positive Behavior Support, Chicago, Ill. United States.

Putnam, R., Barry, S & Rossi, C. (2017). *Implementing positive behavior support within an organization serving individuals with ASD and IDD.* [Conference session]. International Conference on Positive Behavior Support, Chicago, Ill. United States.

Putnam, R. (2017). *Scaling up applied behavior analysis: Implementing multi-tiered systems of support in schools and other organizations.* [Conference session]. Association for Behavior Analysis International 42nd Annual Convention, Chicago, IL. United States.

Putnam, R. & Yanek, K. (2017). *Using data to support classroom PBIS.* [Conference session]. PBIS National Forum, Chicago, Ill. United States.

Putnam, R. & Gould, K. (2017). *Autism spectrum disorder: Across the tiers.* [Conference session]. PBIS National Forum, Chicago, Ill. United States.

Putnam, R., Weise, P., & Sellon, H. (2017). *PBIS in alternative schools.* [Conference session]. PBIS National Forum, Chicago, IL. United States.

Putnam, R. & Barry, S. (2017). *Using data-based decision teams to reduce problem behavior with adults with autism and/or intellectual and developmental disabilities.* [Conference session]. Association for Behavior Analysis International Autism Conference. Chicago, IL. United States.

Putnam, R. & Gould, K. (2017). *Autism Spectrum Disorder: Across the tiers.* [Conference session]. National PBIS Leadership Forum, Chicago, IL. United States.

Putnam, R & Barry, S. (2017). *Improving the effectiveness of tier 2 interventions.* **[**Conference session]. International Conference on Positive Behavior Support, Chicago, IL. United States.

Putnam, R. & Barry, S. (2017). *Implementing organizational-wide PBIS.* [Training series] Children's Hospital of Philadelphia. Philadelphia, PA. United States.

Putnam, R., Barry, S., McDermott, E., & Defalco, G. (2016*). Implementing universal behavior support interventions across a large behavioral analytic organization using data-based decision-making.* [Conference session]. Association for Behavior Analysis International Convention, Chicago, IL. United States.

Putnam, R., Lopes, A., Strout, M., & Barry, S. (2016). *Improving the quality of life of aging individuals with intellectual and developmental disabilities through a multi-tiered system of support (PBS).* [Conference session]. Bridgewell's Living Longer Conference, Framingham, MA. United States.

Donaldson, D. & Putnam, R. (2016). *Utilizing multi-tiered systems of support to enhance the effectiveness of service delivery for individuals with complex behavioral needs.* [Symposium] Berkshire Association for Behavior Analysis and Therapy Annual Conference, Amherst, MA. United States.

Putnam, R., Barry, S., & McDermott, E. (2016). *Improving outcomes for individuals with I/DD using a data-based PBIS/MTSS framework.* [Workshop]. Provider's Council Convention and Expo, Boston, MA. United States.

Putnam, R., & Rossi, C. (2016). *Developing a Tier 1 PBIS plan for students with ASD.* [Conference session]. National PBIS Leadership Forum, Rosemont, IL. United States.

Putnam, R. & Barry, S. (2016). *Implementing a Tier 3 system in an alternative program.* [Conference session]. National PBIS Leadership Forum, Rosemont, IL. United States.

Swain-Bradway, Putnam, R. & Frerks, T. (2016). *Classroom assessment & decision making.* [Conference session]. National PBIS Leadership Forum, Rosemont, IL. United States.

George, J., Putnam, R., & Barry, S. (2016). *Improving behavior support and quality of life: The Department of Developmental Services' PBS Initiative.* [Conference session]. New England Positive Behavior Support Forum, Norwood, MA. United States.

Barry, S., McDermott, E., & Putnam, R. (2016). *Implementation of PBS: Systems, data, and practices.* [Conference session]. New England Positive Behavior Support Forum, Norwood, MA. United States.

Putnam, R. (2016). *Research-based interventions that work with adults with autism.* [Workshop] Association of Developmental Disabilities Providers, Worcester, MA. United States.

Putnam, R. & Donaldson, D. (2016). *What are the evidence-based practices for individuals with ASD? The National Standards Project.* [Workshop]. Bridgewell's Conquering the Cliff: Autism's Journey into Adulthood Conference, Framingham, MA. United States.

Putnam, R., Barry, S., & Bussiere, N. (2016). *Implementing a multi-tiered system of support for individuals with ASD in adult day and residential services.* [Workshop]. Bridgewell's Conquering the Cliff: Autism's Journey into Adulthood Conference, Framingham, MA. United States.

Putnam, R., & Barry, S. (2016). *Improving the effectiveness of Tier 2 interventions.* [Conference session]. Northeast PBIS Network Leadership Forum, Mystic, CT. United States.

Putnam, R., Barry, S., & Defalco, G. (2016). *Improving outcomes for adult individuals with intellectual and developmental disabilities: Implementing a multi-tiered system of behavior supports.* [Conference session]. MassABA Annual Conference. Marlboro, MA. United

Putnam, R., Barry, S., McDermott, E., & Defalco, G. (2016). Developing and implementing data-based decision-making teams for those individuals with developmental disabilities with high-risk behavior within a multi-tiered system of behavior support. [Conference session]. Association for Behavior Analysis International Annual Convention, Chicago, IL. United States.

Freeman, R., & Putnam, R. (2016). *Using organization-wide positive behavior support to improve outcomes for individuals with disabilities.* [Workshop]. International Conference on Positive Behavior Support, San Francisco, CA. United States,

George, H., & Putnam, R. (2016). *Building district capacity for multi-tiered behavioral frameworks.* [Webinar]. School Climate Transformation Grants. Retrieved from http://www.pbis.org/sctg

Putnam, R. (2015). *A multi-tiered system of behavior support: Implications for use in large, applied behavior analytic organizations.* [Conference session]. Berkshire Association for Behavior Analysis and Therapy Annual Conference, Amherst, MA. United States.

Putnam, R. (2015). *Improving outcomes for adults with intellectual and developmental disabilities: Utilizing a multi-tiered behavioral support framework in a large behavior analytic organization.* [Symposium]. Berkshire Association for Behavior Analysis and Therapy Annual Conference, Amherst, MA. United States.

Putnam, R., & Gould, K. (2015). *Supporting students with autism in a multi-tiered approach.* [Conference session]. National PBIS Leadership Forum, Rosemont, IL. United States.

Putnam, R., & Weist, M. (2015). *Embedding mental health into school-wide systems of PBIS.* [Conference session]. National PBIS Leadership Forum, Rosemont, IL. United States.

Putnam, R., Malloy, J., & Perales, K. (2015). Interconnected Systems Framework: Tools for implementation. [Conference session]. National PBIS Leadership Forum, Rosemont, IL. United States.

Putnam, R., Weist, M., Barry, S., & Splett, J. (2015). *Interconnected Systems Framework (ISF).* [Roundtable discussion] National PBIS Leadership Forum, Rosemont, IL. United States.

Bussiere, N., McDermott, E., Souza, B., & Putnam, R. (2015). *Utilizing data collection and analysis software systems for effective data-based decision making.* [Poster presentation]. Annual New England Positive Behavior Support Forum, Norwood, MA. United States.

Fox, C., Putnam, R., & Worcester, J. (2015). *Implementing PBIS: Systems, data, & practices.* [Conference session]. Annual New England Positive Behavior Support Forum, Norwood, MA. United States.

Putnam, R. & Solotar, L. (2015). *Improving behavior support practices with children with ASD.* Stars and Rain Autism Conference. Beijing, China.

Putnam, R. & Barry, S. (2015). *Program-wide PBIS Tiered Fidelity Inventory: Measuring PBIS implementation within an organization serving individuals with intellectual and developmental disabilities.* [Poster presentation]. Annual New England Positive Behavior Support Forum, Norwood, MA. United States.

Putnam, R. & Whitcomb, S. (2014). *PBIS coaches training: Coaching basics.* [Presentation]. Westfield Public Schools. Westfield, MA. United States.

Putnam R.F., Donaldson, D., McCurdy, B, & Thomas, L. (2014). *Perspectives on scaling up PBIS in large behavioral health organizations.* [Conference session]. National Conference for the Association for Positive Behavior Supports. Chicago, IL. United States.

Putnam, R.F., George, J., Rogers, T., LePage, J. & Freeman, R. (2014). *State-wide PBIS systems implementation across two states for adults with developmental disabilities.* [Conference session]. National Conference for the Association for Positive Behavior Supports. Chicago, IL. United States.

Putnam, R.F. (2014). *Improving classroom behavior support practices through applied behavior analysis interventions for students with autism spectrum disorder.* [Workshop]. Annual Conference of the International Association for Behavior Analysis. Chicago, IL. United States.

Dubard, M., Putnam, R.F. & Souza, B. (2014). *Developing and implementing a system-wide data information system to reduce problem behavior*. [Conference session]. Annual Conference of the International Association for Behavior Analysis. Chicago, IL. United States.

Dubard, M., Putnam, R.F. & Joy, M. (2014). *Effectively training direct care therapists serving students with autism*. [Conference session]. Annual Conference of the International Association for Behavior Analysis. Chicago, IL. United States.

Putnam, R.F. (2104). *School-wide positive behavior support.* [Presentation]. BEST Statewide Team. Burlington, VT. United States.

Putnam. R.F. (2013). *Improving classroom behavior support practices for students with ASD*. [Workshop]. Annual Conference of the International Association for Behavior Analysis. Chicago, IL. United States.

Putnam, R.F., Hardy, C.M., Olmi, D.J., Weakley, N.M. (2013). *Classwide PBIS: Improving classwide behavior support in EBD classrooms.* [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Putnam, R.F., & Weiner, B. (2013). *Building systems for supporting students with autism at all 3 tiers of PBIS*. [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Putnam, R.F., Parmalee, J. Clark, P., Brown, L., & Lukenheimer, L. (2013). *Implementing the interconnected system framework in an urban school system.* [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Putnam, R.F., Feinberg, A., Fallon, L. (2013). *Classwide PBIS: Improving on-task behavior in classrooms.* [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Putnam, R.F. (2013). *Integrating mental health services across the tiers: Interconnected Systems Framework System.* [Conference session]. New England Positive Behavior Support Forum. Norwood, MA. United States.

George, J., Putnam, R.F., White, C., Peters, M. (2013). *Universal supports in the Massachusetts DDS PBS initiative.* [Conference session]. New England Positive Behavior Support Forum. Norwood, MA. United States.

George, J., Fox, C. Putnam, R.F., Peters, M. (2013). *Targeted and intensive supports in the DDS PBS initiative*. [Conference session]. New England Positive Behavior Support Forum. Norwood, MA. United States.

Putnam, R.F., & Sousa, B. (2013). *Using data to support School-Wide Positive Behavior Support*

*implementation.* [Invited address]. Annual Conference of Massachusetts Association of Approved Private Schools. Maynard, MA. United States.

Putnam, R.F. (2013). *Improving classroom behavior support practices.* [Workshop]. Annual Conference of Mass ABA. Waltham, MA United States.

Putnam, R.F., & Gould, K. (2012). *Impacting students with autism through all 3 tiers of PBIS.* [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Putnam, R.F., Palmer R., Rodriguez, H., Parmalee, J., Bandison, D., Vinciquerra, M., & Brown, L. (2012). Integrating SMH/PBIS in large urban school systems. [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Fox, C., Dorsey, M.F., Putnam, F., Ricciardi, J. & George, J. (2012). M*assachusetts Department of Developmental Disabilities State-wide Positive Behavior Supports Initiative: An update on the future of behavior supports for individuals served by the DDS.* [Conference session]. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Putnam. R. (2012). *School-wide positive behavior support: Large scale applications of applied behavior analysis.* [Invited address]. Annual Conference of Mass ABA. Waltham, MA. United States.

Putnam, R. Parmalee, J., Vinciquerra, M., Fletcher, M., & Wally, M.S. (2012). *Interconnected systems: School mental health and school-wide positive behavior support.* [Conference session]. Annual Conference of Northeast PBIS Network Leadership Forum. Cromwell, CT. United States.

Putnam, R.F. (2012). *Improving classroom behavior support practices through applied behavior analysis interventions.* [Workshop]. Annual Conference of the International Association for Behavior Analysis. Seattle, WA. United States.

Putnam, R.F. (2012). *School-wide positive behavior support: Effective implementation and its impact in school settings*. [Conference session]. Annual Conference of the International Association for Behavior Analysis. Seattle, WA. United States.

Putnam, R.F., & Robinson Joy, M. (2012). *Improving prosocial behavior and reducing problematic behavior in children with autism.* [Conference session]. Federation for Children with Special Needs Annual Conference: Visions of Community. Boston, MA. United States.

Putnam. R.F. (2011). *School-wide positive behavior support: Effective implementation and its impact in school settings.* [Conference session]. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Putnam, R.F. (2011). *Systems, interventions, and data at the tier 2 level of SW-PBIS.* [Conference session]. New England Positive Behavior Support Forum. Norwood, MA. United States.

Putnam, R.F. (2011). *Respectful and rational decision making: Using evidence in the team process.* [Invited Workshop]. Wauchetts Regional School District. Wauchetts, MA. United States.

Putnam, R.F. (2011). *Effective implementation of school-wide positive behavior supports: Reducing the need for seclusion and restraint.* [Invited address]. Joint Meeting of the Subcommittee on Safety and Services, Interagency Coordinating Committee, United States Department of Health and Human Services. Bethesda, MD. United States.

Putnam, R.F., Gramet, S., Parmalee, J. & Fletcher, M. (2011). *Getting started: Integrating community mental health services into school-wide positive behavior support in a large urban district.* [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Putnam, R.F. & Feinberg, A. (2011). *PBIS in urban alternative school settings: Data-based decision making.* [Conference session]. National PBIS Leadership Forum. Chicago, IL. United States.

Reedy, M.J., & Putnam, R.F. (2011). *Respectful and rational decision making: Using evidence in the team process.* [Invited Workshop]. Massachusetts Administrators of Special Education. Worcester, MA. United States.

Putnam, R.F., & Petruccelli, M.L. (2011). Developing the social skills of students with ASD served in inclusive settings. [Workshop]. Annual Conference of the Association for Behavior Analysis International. Denver, Colorado. United States.

Putnam, R.F., & Grider B. (2011). *Positive behavior supports for highly individualized treatment centers? Yes, there is a place.* [Conference session]. Annual Conference of the International Association for Behavior Analysis. Denver, Colorado. United States.

Kilgus, S. Feinberg, A., & Putnam, R.F. (2010). *Linking the Massachusetts bullying prevention legislation to PBIS.* [Conference session]. New England Positive Behavior Support Forum. Norwood, MA. United States.

Putnam, R.F., & Rist, A. (2010). *Implementing SW-PBIS at the district level: Lessons from the field.* [Conference session]. New England Positive Behavior Support Forum. Norwood, MA. United States.

Putnam, R.F., & Feinberg, A. (2010). *School-wide positive behavioral supports (SWPBS): A tiered system for improving school climate.* [Invited address]. Massachusetts Department of Elementary and Secondary Schools' Summit on Curriculum, Instruction & Assessment. Westborough, MA. United States.

Putnam, R.F., Boltax. R., Cassandra Corley, C., & Moorthy, S. (2010). *Contextual fit & cultural relevancy in different settings.* [Conference session]. National Conference for the Association for Positive Behavior Supports. St. Louis, MO. United States.

Putnam, R.F., & Petruccelli, M.L. (2010). *Developing the social skills of students with ASD served in inclusive settings.* [Workshop]. Annual Conference of the International Association for Behavior Analysis. San Antonio, Texas. United States.

Putnam, R.F. (2009). *Improving prosocial skills: Using social assessments to design effective interventions.* [Invited Workshop]. Annual Conference for the Manitoba Families for Effective Autism Treatment. Winnipeg, Canada.

Putnam, R.F., Handler, M., Feinberg, A., McGrath, C., Glass Kendorski, J., & Landgraf, J. (2009). *Implementation of SW-PBS in core urban schools: Lessons learned.* [Conference session]. National Conference for the Association for Positive Behavior Supports. Jacksonville, FL. United States.

Putnam, R.F. (2010). *Multi-Tier System of Support – Behavior Schoolwide Positive Behavior Supports (SWPBS)* [Presentation]. Boston Public Schools. Boston, MA. United States.

Putnam, R.P. (2009). *Improving the social skills of individuals with ASD in inclusive classrooms.* [Conference session]. Federation for Children with Special Needs Annual Conference. Boston, MA. United States.

Putnam, R.F. (2008). *Developing effective classwide positive behavior support interventions in public schools.* [Workshop]. Annual Conference of the International Association for Behavior Analysis. Chicago, Ill. United States.

Putnam, R.F. (2008). *Moving from treatment to practice in evidence-based practice.* [Conference session]. Annual Conference of the International Association for Behavior Analysis. Chicago, Ill. United States.

Putnam, R.F. (2008). *Secondary prevention and tertiary interventions.* [Conference session]. BEST Institute. Killington, VT. United States.

Putnam, R.F. (2008). *Secondary & tertiary school-wide positive behavior support.* [Presentation]. Vermont Department of Education. Burlington, VT. United States.

Putnam, R.F. (2008). *Improving prosocial behavior and reducing problematic behavior.* [Invited address]. Autism Education Network. Santa Clara, CA. United States.

Putnam, R.F. (2008) *Functional behavioral assessment and behavior intervention plans*. [Invited Presentation]. Discipline of Students with Special Needs in Massachusetts. Dedham, MA. United States.

Putnam, R.F. (2008). *School-wide positive behavior support.* [Presentation]. Vermont Department of Education. Killington, VT. United States.

Putnam, R. & Handler, M. (2008). *Beyond the ODR: Using an RTI Model to improve prosocial skills.* [Conference session]. National Conference for the Association for Positive Behavior Supports. San Diego. C.A. United States.

Putnam, R.F. (2008). *Building secondary school-wide positive behavior support interventions.* [Presentation]. Addison-Northeast Public Schools. Bristol, VT. United States.

Putnam, R.F. (2008). *School-wide positive behavior support.* [Presentation[. Vermont Department of Education. Killington, VT. United States.

Putnam, R. & Kincaid, D. (2008). *Data-based decision making at the secondary and tertiary levels.* [Conference session]. National Conference for the Association for Positive Behavior Supports. San Diego. United States.

Putnam, R.F. (2008). *Building behavior support plans.* [Presentation]. Addison-Northeast Public Schools. Bristol, VT. United States.

Kincaid, D., Putnam, R. & Childs., K. (2007). *Data-based decision making: Using data within SWPBS.* [Conference session]. National Positive Behavior Support Implementers Conference. Chicago, IL. United States.

Putnam, R.F. & McCurdy, B. (2007). *Urban schools: Strategies at the building level.* [Conference session]. National Positive Behavior Support Implementers Conference. Chicago, IL. United States.

Putnam, R.F. (2007). *Building readiness to implement school-wide positive behavior support.* [Presentation]. Vermont Department of Education. Killington, VT. United States.

Putnam, R.F. (2007). *School-wide positive behavior support.* [Conference session]. BEST Summer Institute: Vermont Department of Education. Killington, VT. United States.

Putnam, R.F. (2007). *School-wide positive behavior support.* [Presentation]. Addison-Northeast Public Schools. (2007). Bristol, VT. United States.

Putnam, R.F. (2007). *Developing school-wide positive behavior support plans.* [Presentation]. Addison-Northeast Public Schools. Bristol, VT. United States.

Coyne, M., Sailor, W., Kincaid, D., & Putnam, R. (2007). *Response to intervention and positive behavior support.* [Conference session]. National Conference for the Association for Positive Behavior Supports. Boston, MA. United States.

Putnam, R.F. (2007). *Improving prosocial behavior and reducing problematic behavior in school services.* [Conference session]. Mind and Body in Autism: Educational, Psychological, and Medical Perspectives Conference, Columbia, University. New York, NY. United States.

Putnam, R.F., Thier, K. & Handler, M.H. (2007). *Improving classroom behavior support practices through applied behavior analysis interventions.* [Conference session]. Annual Conference of the International Association for Behavior Analysis. San Diego, CA. United States.

Putnam, R.F., & Feinberg, A. (2007). *Introduction to school-wide positive behavior support*. [Conference session]. BEST Institute. Killington, VT. United States.

Putnam, R. & Feinberg. A. (2007). *Using data under a response to intervention model with students with Autism Spectrum Disorders.* [Presentation). Massachusetts Department of Education's Building Expertise on Serving Students with Autism Spectrum Disorders in Inclusive Settings. Worcester, MA. United States.

Putnam R.F., Handler, M., Riley, H., Dunlap. G., & Strain, P. *Teaching strategies for students with Autism Spectrum Disorders in the general education classroom.* [Institute]. Massachusetts Department of Education. Randolph, MA. United States.

Methe, S. & Putnam R.F. (2006). *Linking academic and behavioral improvement models.* [Conference session]. Annual Conference of Association for Positive Behavior Support. Reno, Nevada. United States.

Putnam, R.F., Filter, K., McIntosh, K. & McKenna, M. (2006). *Interactions between academic skills and problem behavior: Results from current research studies.* [Conference session]. Annual Conference of Association for Positive Behavior Support. Reno, Nevada. United States.

Putnam, R.F., Thier, K., & Handler, M. (2006). *Improving classroom behavior support practices through applied behavior analysis interventions.* [Workshop]. Annual Conference Annual Convention of the Association for Behavior Analysis. Atlanta, GA. United States.

Feinberg, A.B., Putnam, R., & Handler, M.W. (2006*). Positive Schools: School-wide positive behavior suppor*t. [Conference session]. Annual Conference of the National Association of Elementary School Principals. San Antonio, TX. United States.

Connell, J., Their, K., & Putnam, R.F. (2005). *Evaluating outcomes and identifying targeted individual supports.* [Conference session as part of a symposium]. Classroom-wide behavior support: Using data to identify needs and solutions. Annual Convention of the National Association of School Psychologists. Atlanta, GA. United States.

Putnam, R.F., Feinberg, A. (2005). *Systematic academic and behavioral support practices to improve student achievement*. [Conference session]. Annual Massachusetts Title I Conference. Hyannis, MA. United States.

O'Leary-Zonarich, C.A., Rey, J., Pisacreta, J., Handler, M.W., & Putnam, R.F. (2004). *Applications of school-wide behavioral consultation in urban elementary and middle schools.* [Conference session as part of a symposium]. Developing effective school-wide behavior support interventions to improve urban schools. Annual Convention of the Association for Behavior Analysis. Boston, MA. United States.

Handler, M.W., Putnam, R.F., & Feinberg, A. (2004). *Effective school-wide behavior support practices in urban schools.* [Conference session]. Annual Convention of the National Association of School Psychologists. Dallas, TX. United States.

Putnam, R.F., Handler, M.W. & Davis, C. (2004). *Training for trainers of school-wide positive behavior support.* [Conference session presented as part of a symposium]. Establishing active supervision practices and systems. Naperville, IL. United States.

Putnam, R.F. & Handler, M.H. (2004). *Evaluations of school-wide behavior support interventions in public schools*. [Poster presentation]. Annual Convention of the American Psychological Association. Honolulu, H.A. United States.

Rey, J., Handler, M.W., & Putnam, R.F. (2003). *Positive Schools: Effective school-wide discipline practices in urban districts.* [Conference session as part of a symposium]. School-wide behavior support interventions in urban public schools. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Rey, J., Handler, M.W., & Putnam, R.F. (2003). *Positive Schools: Effective school-wide discipline practices in urban districts.* [Conference session as part of a symposium]. School-wide behavior support interventions in urban public schools. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Putnam, R.F., Handler, M.W., & Howard, H. (2003). *Improving school-wide practices to meet the No Child Left Behavior (NCLB) legislation requirement using the Positive Schools program.* [Conference session as part of a symposium]. School-wide behavior support interventions in urban public schools. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Handler, M.W., & Putnam, R.F. (2003). *An analysis of special education practices that predict more restrictive placements.* [Conference session as part of a symposium]. School-wide behavior support interventions in urban public schools. Annual Conference of The Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Rey, J., Handler, M.W., & Putnam, R.F. (2003). *Maintenance outcomes of prevention-focused whole-school behavior support.* [Conference session as part of a symposium]. Behavior consultation to public schools: improving student discipline practices and academic achievement through prevention-focused and systems-wide intervention. Annual Association for the Advancement of Behavior Therapy, Boston, MA. United States.

Handler, M.W., & Putnam, R.F. (2003). *Academic achievement of students receiving school-wide behavior support.* [Conference session presented as part of a symposium]. Behavior consultation to public schools: Improving student discipline practices and academic achievement through prevention-focused and systems-wide intervention. Annual Association for the Advancement of Behavior Therapy, Boston, MA. United States.

Putnam, R.F., Handler, M.W., & Howard, H. (2003). *Improving school-wide practices to meet the No Child Left Behavior (NCLB) legislation requirement using the Positive Schools program.* [Conference session as part of a symposium]. School-wide behavior support interventions in urban public schools. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Handler, M.W., & Putnam, R.F. (2003). *An analysis of special education practices that predict more restrictive placements.* [Conference session presented as part of a symposium]. School-wide behavior support interventions in urban public schools. Annual Conference of The Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Rey, J., Handler, M.W., & Putnam, R.F. (2003). *Maintenance outcomes of prevention-focused whole-school behavior support.* [Conference session as part of a symposium]. Behavior consultation to public schools: Improving student discipline practices and academic achievement through prevention-focused and systems-wide intervention. Annual Association for the Advancement of Behavior Therapy, Boston, MA. United States.

Handler, M.W., & Putnam, R.F. (2003). *Academic achievement of students receiving school-wide behavior support.* [Conference session as part of a symposium]. Behavior consultation to public schools:

Improving student discipline practices and academic achievement through prevention-focused and systems-wide intervention. Annual Association for the Advancement of Behavior Therapy, Boston, MA. United States.

Putnam, R.F., Handler, M.W. & O'Leary-Zonarich, C. (2003). *Improving academic achievement using school-wide behavioral support interventions.* [Conference session as part of a symposium]. School-wide positive behavioral support: The next level. Annual Association for Behavior Analysis. San Francisco, CA. United States.

Pierce-Jordan, S., O'Leary-Zonarich, C. & Putnam, R.F. (2003). *Systematically enhancing the classroom for children with developmental disabilities: a preschool application.* [Conference session as part of a symposium]. Applications of ABA principles in conducting program evaluations to improve educational programming. Annual Association for Behavior Analysis. San Francisco, CA. United States.

O'Leary-Zonarich, C., Codding, R. & Putnam, R.F. (2003). *Systematically enhancing the classroom for children with developmental disabilities: a middle school application.* [Conference session as part of a symposium]. Applications of ABA principles in conducting program evaluations to improve educational programming. Annual Association for Behavior Analysis. San Francisco, CA. United States.

Handler, M.W., Perry, L.A., Rey, J., & Putnam, R.F. (2003). *Using functional assessment practices to design effective classroom behavior support practices.* [Conference session presented as part of a symposium]. Issues regarding the delivery of behavior analytic services in school settings. Annual Association for Behavior Analysis. San Francisco, CA. United States.

Handler, M.W., & Putnam, R.F. (2003). *Beyond the individual: Systematically enhancing classrooms for children with developmental disabilities.* [Conference session as part of a symposium]. Applications of ABA principles in conducting program evaluations to improve educational programming. Annual Association for Behavior Analysis. San Francisco, CA. United States.

Putnam, R.F. (2003). *Functional behavior assessment and behavior intervention plans.* [Workshop]. Lorman Education Services. Boston, MA. United States.

Putnam, R.F. (2003). *Positive behavior supports: Effective school-based interventions for students with challenging behavior.* [Conference session]. Federation for Children. Boston, MA. United States.

Putnam, R.F., Handler, M.W., Rey, J., & O'Leary-Zonarich, C. (2003). *Positive Schools: System-wide application of positive behavior support.* [Conference session]. First International Conference on Positive Behavior Support. Orlando, FL. United States.

Handler, M.W., Coniglio, J., McCarty, J., Putnam, R.F., Tracey, S., & Selva, M. (2003). *Special education systems' use of positive behavior support to prevent out of district placements.* [Symposium]. First International Conference on Positive Behavior Support. Orlando, FL. United States.

Putnam, R.F. (2003). *Positive behavior supports: Effective school-based interventions for students with challenging behavior.* [Invited Workshop]. Federation for Children/Family TIES of MA/MA Families Organizing for Change/Parents for Residential Reform/Parent Professional Advocacy League. Boston, MA. United States.

Putnam, R.F., & Handler, M.W. (2003). *Positive Schools: Using partnerships to expand the role of school psychologists.* [Conference session]. Annual Convention of the National Association of School Psychologists. Toronto, Canada.

Putnam, R.F., Handler, M.W., Rey, J. (2003). *Best practices in behavior support and violence prevention.* [Conference session]. Annual Convention of the National Association of Elementary School Principals. Anaheim, CA. United States.

Handler, M.W., & Putnam, R.F. (2003). *Expanding possibilities: Innovative predoctoral internships for school psychologists.* [Conference session]. Annual Convention of the National Association of School Psychologists. Toronto, Canada.

Putnam, R.F., Handler, M.W., & Rey, J. (2003). *Best practices in behavior support and violence prevention.* [Conference session]. Annual Convention of the National Association of Elementary School Principals. Anaheim, CA. United States.

Handler, M.W., Rey, J., Putnam, R.F., & McCarty, J. (2002). *Effective behavior support interventions to prevent disruptive behaviors in general education classroom settings.* [Conference session]. Annual Meeting of the Society for Prevention Research. Seattle, WA. United States.

Putnam, R.F. (2002). *Functional behavior assessment.* [Workshop series]. Lowell Public Schools. Lowell, MA. United States.

Putnam, R.F. (2002). *Functional behavior assessment.* [Workshop]. Autism Support Center. Danvers, MA. United States.

Handler, M.W., & Putnam, R.F. (2002). *Using ABA to establish and maintain effective school-wide discipline practices using the Positive Schools program.* [Conference session as part of a symposium]. Using ABA to improve disciplinary and academic outcomes in public schools. Annual Berkshire Conference on Behavior Analysis and Therapy. Amherst, MA. United States.

Putnam, R.F. (2002). *Using functional behavioral assessment to develop effective behavior support plans.* [Presentation series]. Lowell Public Schools. Lowell, MA. United States.

Putnam, R.F., & Handler, M. (2002). *Prevention of youth violence.* [Workshop]. The May Institute. Norwood, MA. United States.

Putnam, R.F., & Handler, M. (February 2002). *Effective discipline practices.* [Workshop]. The May Institute. S. Harwich, MA. United States.

Putnam, R.F., & Handler, M.W. (2002). *Positive Schools: A system-wide approach to improving discipline practices in schools.* [Conference session]. Annual Convention of the National Association of School Psychologists. Chicago, IL. United States.

Putnam, R.F. (2002). *Functional behavior assessment.* [Workshop series]. South Shore Collaborative. Hingham, MA. United States.

Putnam, R.F. (2002). *Effective discipline practices.* [Presentation]. B.M.C. Durfee High School. Fall River, MA. United States.

Putnam, R.F., & Malonson, J. (2002). *Developing cost-effective special education services for students with challenging behavior.* [Workshop]. Annual Convention of the Council for Exceptional Children. New York, NY. United States.

Putnam, R.F. (2002). *Functional behavior assessment.* [Workshop series]. South Shore Collaborative. Hingham, MA. United States.

Putnam R.F. & Malonson, J. (2002). *Providing effective educational services to middle school and junior high school students with Asperser Disorder or high functioning autism.* [Workshop]. National Urban Special Education Directors Meeting.

Putnam, R.F., Handler, M.W., Rey, J., & O'Leary-Zonarich, C. (2002). *Classwide behavior support interventions: Using functional assessment practices to design effective interventions in general classroom settings.* [Conference session in a Symposium]. Establishing and maintaining proactive

discipline systems at the school, classroom, and individual student levels within schools. Annual Conference of the Association for Applied Behavior Analysis. Toronto, Canada.

Handler, M., Putnam, R., Tracey, S., & Rey, J. (2001). *Effective classroom behavior support strategies: A component of the Positive Schools program.* [Conference session]. Annual Convention for the Association for Behavior Analysis, New Orleans, LA. United States.

Putnam, R. (2001). *Effective disciplinary strategies.* [Workshop]. Assabet Valley Collaborative, Northboro, MA. United States.

Putnam, R., O'Leary, C., Lesser, A. & Ellis, J. (2001). *Pervasive Developmental Disorders, Effective educational interventions.* [Workshop]. Autism Support Center, Sturbridge, MA. United States.

Putnam, R., & Pierce-Jordan, S. (2001). *Pervasive Developmental Disorders, Effective educational interventions for parents.* [Workshop]. Autism Support Center, Leominster, MA. United States.

Putnam, R., & Rey, J. (2001). *Effective school-wide disciplinary strategies.* [Workshop]. Somerset Public Schools, Somerset, MA. United States.

Putnam, R. & Handler, M. (2001). *Positive Schools: A comprehensive school-wide approach to improving discipline and behavior support practices in public schools.* [Conference session]. Annual Convention for the Association for Behavior Analysis, New Orleans, LA. United States.

Putnam, R. (2001). *Assessment of social skills using the Walker-McConnell Scale of Social Competence and School Adjustment.* [Presentation]. North Middlesex Public Schools, Townsend, MA. United States.

Putnam, R. & Pace, G. (2001). *Traumatic brain injury.* [Presentation.] Brockton Public School System, Brockton, MA. United States.

Putnam, R., Rey, J., & O'Leary, C. (2001). *Effective social skills training.* [Workshop]. Autism Support Center, Leominster, MA. United States.

Putnam, R. & Howell, L. (2001). *PDD/special needs/Best strategies to use in the classroom.* [Presentation]. North Middlesex Regional High School, Townsend, MA. United States.

Putnam, R. & Ramirez, C. (2001). *Writing measurable objectives.* [Workshop] South Shore Collaborative, Hingham, MA. United States.

Putnam, R. & Selva. M. (2001). *Working with students with challenging behavior.* [Presentation]. Nashoba Regional School, Bolton, MA. United States.

Putnam, R. & Ramirez, C. (2001). *Teaching social skills.* [Workshop]. South Shore Collaborative, Hingham, MA. United States.

Putnam, R. & Selva, M. (2001). *Effective services for students with pervasive developmental disorder.* [Presentation]. Leominster Public Schools, Leominster, MA. United States.

Putnam, R., Handler, M. & Jefferson, G. (2000). *Evaluating and designing effective system-wide consultation services.* [Conference presentation]. Association for Behavior Analysis Convention, Washington, DC. United States.

Putnam, R. (2000) *Using functional behavioral assessment to develop behavior support plans.* [Presentation]. Brockton Public Schools, Brockton, MA. United States.

Putnam, R. (2000). *How to write objective and measurable IEP objectives.* [Presentation]. Brockton Public Schools, Brockton, MA. United States.

Putnam, R. & Handler, M. (2000). *Educating students with challenging behavior in the classroom.* [Presentation]. Lunenburg Public Schools, Lunenburg, MA. United States.

Putnam, R. (2000). *Data collection strategies.* [Presentation]. Lunenburg Public Schools, Lunenburg, MA. United States.

Putnam, R. (2000). *Walker-McConnell Scale of Social Competence and School Adjustment - Adolescent Version.* [Presentation]. Lunenburg Public Schools, Lunenburg, MA. United States.

Putnam, R. (2000). *Walker-McConnell Scale of Social Competence and School Adjustment - Elementary Version.* [Presentation]. Lunenburg Public Schools, Lunenburg, MA. United States.

Putnam, R. (2000). *Effective practices for children with pervasive developmental disorders and developmental disabilities*. [Presentation]. Department of Mental Retardation, North Central Region. Fitchburg, MA. United States.

Putnam, R. (2000). *Walker-McConnell Scale of Social Competence and School Adjustment -Adolescent Version.* [Presentation]. Harvard Medical School. Belmont, MA. United States.

Putnam, R., Handler, M. & Tracey, S. (2000). *Overview of mental health disorders and associated syndromes.* [Presentation]. Brockton Public Schools, Brockton, MA. United States.

Putnam, R.F. (1999). *System-wide behavior management.* [Workshop]. The annual conference of the Massachusetts School Psychologist Association, Worcester, MA. United States.

Jefferson, G.L., Petetit, L., & Putnam, R.F. (1999). *Evaluation of the relationship between problem behavior and basic academic skills.* [Poster session]. The annual conference of the Association of Applied Behavior Analysis, Chicago, IL. United States.

Putnam, R.F. & Jefferson, G.L. (1999). *A behavioral analysis of office referrals within a public elementary school*. [Poster session]. The annual conference of the Association for Applied Behavior Analysis. Chicago, IL. United States.

Putnam, R.F., Jefferson, G.L., & Petetit, L. (1999). *Promoting positive school-wide educational outcomes: Strategies for academic and behavioral change.* [Workshop]. The annual conference of the Association for Applied Behavior Analysis, Chicago, IL, United States.

Putnam, R.F., Jefferson, G.L. (1999). *Conducting functional behavioral assessments in public school settings.* [Workshop]. The annual conference of the Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Putnam, R.F. & Handler M. (1999). *School-wide positive behavioral support strategies.* [Workshop]. The annual meeting of the Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Putnam, R.F. & Jefferson, G.L (1999). *Functional assessment: A new standard of practice for school-based psychologists.* [Conference session]. The annual conference of the Berkshire Association for Behavior Analysis and Therapy, Amherst, MA, United States.

Putnam, R.F. (1998). *Using applied behavior analysis procedures with students with autism.* [Presentation]. Hingham Public Schools, Hingham, MA. United States.

Putnam, R.F. (1998). *Applied behavior analysis.* Brockton Public Schools. [Presentation]. Brockton, MA. United States.

Putnam, R.F. (1998). *Applied behavior analysis.* [Presentation]. FLAC Collaborative. Fitchburg, MA. United States.

Putnam, R.F. (1998). *Pervasive development disorders: Developing cost-effective services.* [Invited Workshop]. Autism Resource Center: North Central Area Public Schools Special Education Directors. Worcester, MA. United States.

Putnam, R.F. (1998). *Pervasive development disorders: Developing effective services.* [Invited Workshop]. Autism Resource Center. Worcester, MA United States.

Putnam, R.F. (1998). *What is new about the old functional behavior assessment.* [Invited Workshop]. Annual Convention of the Massachusetts School Psychologist Association, Worcester, Mass. United States.

Putnam, R.F., Jefferson, G.L. (1998). *Conducting functional behavioral assessments in public school settings.* [Workshop]. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Neill, J.C.., Waters, J.M. & Putnam R.F. (1997). *Recent advances in behavioral pharmacology in applied settings for individuals with mental retardation.* [Conference session]. Annual Conference of the Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Putnam, R.F. (1997). *Using functional behavioral assessment to develop effective behavior support plans.* [Presentation]. Brockton Public Schools. Brockton, MA. United States.

Putnam, R.F. (1997). *Using applied behavior analysis procedures with students with autism.* [Presentation]. Mansfield Public Schools. Mansfield, MA. United States.

Putnam R.F. (1995). *Pervasive developmental disorders - Diagnosis and treatment.* [Presentation]. Brockton Special Education Department, Brockton, MA. United States.

Putnam R.F. (1995). *Pervasive developmental disorders - Diagnosis and treatment II.* [Presentation] Brockton Special Education Department, Brockton, MA. United States.

Putnam R.F. (1994). *Lifestyles of the behaviorally and psychiatrically challenged.* [Invited Presentation]. Massachusetts Department of Mental Retardation, Waltham, MA. United States.

Putnam, R.F. (1994). *Crisis intervention, stabilization, and prevention services.* [Invited address]. Massachusetts Department of Mental Retardation Human Rights Conference, 10th Annual Conference, Sturbridge, MA. United States.

Putnam, R.F., O'Meara, R., Harris, J., and Quinn, F. (1994). *The development and implementation of crisis intervention, stabilization, and prevention services.* [Invited address]. Massachusetts Department of Mental Retardation Senior Management Staff. Andover, MA. United States.

Babcock, R., & Putnam, R.F. (1993). *The development and persistence of performance at a community mental health agency: Lessons learned in facing exigencies.* [Conference session]. Annual Convention of the Association for Behavior Analysis, Chicago, IL. United States.

Apolito, M., Bates, A., Coppola, D., Cznarty-Fioriti, T., Tracy, R., and Putnam, R.F. (1993). *Increasing the quality of services in residential settings through competency-based applied behavior analysis training.* [Conference session]. Annual Convention of the Association for Behavior Analysis, Chicago, IL, United States.

Putnam, R.F., and Babcock, R. (1993). *Improving the management of quality in community-based programs during times of diminishing returns.* [Conference session]. Annual Convention of the Association for Behavior Analysis, Chicago, IL United States.

Putnam, R. Apolito, M., Hirsch, M., Harris, J., Roberts, S., and Gorvin, J. (1992). *Responding to crisis with individuals with developmental disabilities: A behavioral community approach.* [Conference

session]. Annual Convention of the Association for Behavioral Analysis, San Francisco, CA. United States.

Babcock, R., and Putnam, R.F. (1992). *An analysis of the importance of monetary contingencies in maintaining behavioral supervision.* [Conference session]. Annual Convention of the Association for Behavior Analysis, San Francisco, CA. United States.

Babcock, R., and Putnam, R.F. (1992). *The development and persistence of performance management at a CMHC: Connecting staff efforts and client outcomes.* [Conference session]. Florida Association for Behavior Analysis, Orlando, FL. United States.

Apolito, P.M., Putnam, R.F., Harris, J., Hirsch, M., and Barrett, R. (1991). *Crisis intervention in the community for individuals with mental retardation.* [Conference session]. Annual Convention of the American Association on Mental Retardation. Washington, DC. United States.

Putnam, R.F. (1991). *Behavior management strategies with children who are deaf.* [Invited session]. South Shore Collaborative. Hingham, MA. United States.

Babcock, R., Putnam, R., Milczarek, M., and Shaw, C. (1991). *Implementing performance management in a community mental health center.* [Conference session]. Annual Convention of the Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Babcock, R., Putnam, R., and Milczarek, M. (1991). *Performance management at the South Shore Mental Health Center: Initial efforts and results.* [Conference session]. Association for Behavior Analysis, Atlanta, GA. United States.

Apolito, P.M., Roberts, S., Harris, J., Hirsch, M., and Putnam, R.F. (1991). *Analysis of the relationship between DSM-III diagnosis, target behaviors, and treatment strategies with mentally retarded individuals.* [Conference session]. Association for Behavior Analysis, Atlanta, GA. United States.

Apolito, P.M., Putnam, R., & Shannon, D. (1990). *A crisis intervention model for individuals with mental retardation living in the community.* [Poster presentation]. Berkshire Association for Behavior Analysis and Therapy. Amherst, MA. United States.

Shannon, D., Apolito, M., Putnam, R., Hirsh, M., Harris, J., Roberts, S., Tracy, R., & Rose, B. (1990). *Emergency outreach: Treating individuals with mental retardation and severe behavior problems in a psychiatric hospital.* [Poster presentation]. Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Putnam, R., Apolito, P.M., Roberts, S., Shannon, D., Harris, J., & Hirsch, M. (1990). *Treating individuals with mental retardation and severe behavior problems in a psychiatric hospital*. [Poster presentation]. Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Dorsey, M.F., Apolito, P.M., Putnam, R., Rebello, M., & Warren M. (1990). *The emergency services inpatient unit: Treatment of acute behaviorally disordered patients in an inpatient psychiatric hospital.* [Conference session]. Association for Behavior Analysis, Nashville, TN. United States.

Putnam, R., Apolito, P.M., O'Meara, R., Russo, D.C., & Shannon, D.M. (1990). *Maintaining severe behavior problem clients in community settings: The emergency services model.* [Symposium]. Association for Behavior Analysis, Nashville, TN. United States.

Babcock, R., Putnam, R., & Kupfer, J. *Implementing a community mental health center matrix management system.* [Conference session]. Association for Behavior Analysis, Nashville, TN. United States.

Putnam, R.F. (1990). *Working with behaviorally and psychiatrically challenged youth*. [Invited Presentation]. Brockton School Department, Brockton, MA. United States.

Babcock, R., Putnam, R., and Milczarek, M. (1990). *Implementing a matrix-based performance management system in a community mental health center*. [Conference session]. Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Putnam, R. (1990). *Crisis intervention services for individuals with mental retardation.* [Conference session]. National Association for the Dually Diagnosed, Boston, MA.

Putnam R.F. (1989). *Managing your child's behavior*. [Invited Presentation]. South Shore Collaborative. Hingham, MA. United States.

Putnam, R., Shannon, D., Apolito, P.M., Dorsey, M.F., Harris, J., Hirsch, M., and O'Meara, R. (1989). *The development of a regional crisis team for individuals with mental retardation.* [Poster presentation]. Berkshire Association for Behavior Analysis and Therapy, Amherst, MA. United States.

Putnam, R.F. (1987). *The use of EMG biofeedback to produce relaxation with mentally retarded individuals.* [Conference session]. New England Society for Behavioral Analysis and Therapy. Boston, MA. United States.

Putnam, R.F. (1986). *Conditioning EMG activity in individuals with moderate mental retardation.* [Poster presentation]. Annual Convention of the Association for Behavior Analysis, Milwaukee, Wisconsin, United States.

Putnam, R.F. (1985). *The use of EMG biofeedback with mentally retarded individuals.* [Invited address]. Boston College Behavioral Society, Boston, Massachusetts. United States.

Putnam, R.F. (1985). *The use of EMG biofeedback to produce relaxation in mentally retarded subjects*. [Conference presentation]. Northeast Regional Convention of the American Association of Mental Deficiency, Burlington, Vermont. United States.

Putnam, R.F., and Pizzolato, G. (1982). *An initial communication system.* [Poster presentation]. Northeast Regional Convention of the American Association on Mental Deficiency, Providence, Rhode Island. United States.

Buron, S., and Putnam, R.F. (1976). *Family-style dining for the mentally retarded.* [Invited Presentation]. Conference on Feeding Techniques for the Multihandicapped Child, Amherst, Massachusetts. United States.

Ahern, K., and Putnam, R.F. (1975). *Environmental modifications.* [Workshop]. Walter E. Fernald State School Environmental Conference. Waltham, MA. United States.

**EVALUATIONS**

Putnam, R., Malinovsky, J. & Legaspi, D. (2018). ASD Classroom Program Evaluation in Santa Clara, California County Office of Education

Putnam, R.F. (2016). Evaluation of the Al-Shafallah Center for Children with Special Needs program in Doha, Qatar.

Putnam, R., Martin, D., Fallon, L. & Baker, L. (2014). Educating Students with Autism Spectrum Disorders in the Worcester Public Schools: Specialized Approaches to Individualized Learning (S.A.I.L.) Program Evaluation

Martin, D., Miller, T. & Putnam, R. (2014). Program Evaluation of ABA Services in Millbury Public Schools

Putnam, R. & Martin, D., Fallon, L, Baker, L. (2014). Evaluation of the Wachusett Regional School District ABA program.

Putnam, R.F. (2004). Evaluation of services for students with ASD in the Lexington Public Schools.

Connell, J. & Putnam, R.F. (2004). An Evaluation of Preschool and Early Elementary Educational Services for Students with Pervasive Developmental Disabilities in the Stoneham Public School District.

Putnam R.F. & Ramirez-Platt (2003). Evaluation of services for students with ASD in the SEEM Collaborative.

Handler M.H. & Putnam, R. (2002). Analysis of Out of district Special Education Placements of the Trenton Public School District.

Putnam, R.F. (2001). Evaluation of the instructional and behavior support services provided to students with developmental disabilities of the Groton Dunstable Middle and High Schools.

Putnam, R.F. (2000). An evaluation of the violence and drug prevention services provided by the Barnstable Public Schools - Elementary Schools.

Putnam, R.F. (1999). Evaluation of behavior support in the Leominster Public Schools.

Putnam, R.F. (1999). Evaluation of the behavioral support services of the Leominster Public Schools.

Putnam, R.F. (1991). Evaluation of the substantially separate and multi-handicapped programs of the Brockton Public Schools.

# Appendix B: Materials Considered

| Document Name | Bates #(s) |
|---|---|
| The United States' requests for production of documents and interrogatories, and the State's written responses and objections, as considered relevant to opinions expressed | |
| Publicly available school websites of the schools visited on site visits | |
| Information about the schools I visited on site visits from the following websites: https://gaawards.gosa.ga.gov/analytics/K12ReportCard, https://schoolgrades.georgia.gov/, https://gaawards.gosa.ga.gov/analytics/saw.dll?dashboard | |
| The State's Responses to Interrogatory 13, 17, 19, 20, and 21 | |
| DBHDD Contract, ABH000004 | ABH000004 |
| Albany Area CSB FY22 Apex Contract, R0078853, Exhibit 784, Lisa Oosterveen Deposition, February 23, 2023. | R0078853 |
| Project AWARE Draft White Paper, GA00307769, Exhibit 689, Jason Byars Deposition, December 2, 2022 | GA00307769 |
| Email thread from Jason Byars to Emily Graybill, GA00310731, Exhibit 694, Jason Byars Deposition, December 2, 2022. | GA00310731 |
| GA05559744 Apex Y6 Annual Evaluation Slide Deck | GA05559744 |
| Apex Year 7 Evaluation Slide Deck, GA05558501 | GA05558501 |
| Year 5 Apex Eval Results Slideshow, GA01749707 | GA01749707 |
| Daniel J. Losen & Paul Martinez, Lost Opportunities, The Center for Civil Rights Remedies (Oct. 2020) https://civilrightsproject.ucla.edu/research/k-12-education/school-discipline/lost-opportunities-how-disparate-school-discipline-continues-to-drive-differences-in-the-opportunity-to-learn/Lost-Opportunities-REPORT-v17.pdf. | |
| Daniel J. Losen, Discipline Policies, Successful Schools, and Racial Justice, National Education Policy Center (Oct. 2011) https://nepc.colorado.edu/sites/default/files/NEPC-SchoolDiscipline.pdf. | |
| GNETS Rule, Ga. Comp. R. & Regs. 160-4-7-.15 | |
| PBIS Training Memo, Exhibit 976, Justin Hill 30(b)(6) Deposition, March 6, 2023 | |
| Schools and Districts, Georgia Department of Education, https://www.gadoe.org/External-Affairs-and-Policy/AskDOE/Pages/Schools-and-Districts.aspx | |
| Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, KFF, available at https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D | |
| kittelman-et-al-2022-allocating-resources-for-tier-2-and-3-implementation-within-positive-behavioral-interventions-and | |
| Barbra Trader et al., Promoting inclusion through evidence-based alternatives to restraint and seclusion, 42 Research Practice Persons Severe Disabilities 75-88 (2017) | |
| Special Education Teacher Preparation in Classroom Management | |
| Why Aren't Students with Severe Disabilities Being Placed in General Education Classrooms | |
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| Cost Efficacy Analysis of Out of District Placements | |
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| ISF v2 Implementation Guide | |
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| Exe Director dep 10152022 | |
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| DBHDD Organization Charts 01-16-2019 | GA00000334 |
| FY18 Winter LEA Collaborative Powerpoint 12-6-2017 | GA00013646 |
| Email from Dante McKay to Judy Fitzgerald re Urgent Request | GA00017470 |
| Email from Judy Fitzgerald to Dante McKay re Apex 3.0 Award Summary | GA00018584 |
| SEEDS Webinar Flyer | GA00019795 |

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| PBIS Booklet 11-2016 | GA00019840, GA00019861 |
| Tier 1 Fidelity 2013-2016 excel spreadsheet | GA00019841 |
| School PBIS Teams Trained 2009-2016 spreadsheet | GA00019842, GA00019871 |
| email from Garry McGiboney to Deb Gay re update | GA00019849 |
| email from Justin Hill to Deb Gay re early draft PBIS booklet | GA00019859 |
| Scanned from a Xerox Multifunction Printer | GA00019865 |
| IDT MOU_SIGNED | GA00019890 |
| IDT Operating Guidelines_2016_final | GA00019895 |
| PBIS Legislator Booklet, Fall 2016 | GA00019954 |
| IDT Operating Guidelines, December 2016 | GA00020264 |
| SBOE Item Template Grant Amendment - GNETS | GA00020429 |
| GNETS Directors Meeting 3-18-19 Powerpoint | GA00027309 |
| email from Doug Reineke to Judy Fitzgerald re Apex Expansion - Statewide Cost Estimates | GA00002241 |
| Apex Expansion - Statewide Cost Estimates Excel Spreadsheet | GA00002242 |
| email from Dante McKay to Judy Fitzgerald re Apex question | GA00002736, GA00004470 |
| AFY19 Senate Appropriations Subcommittee- Human Development Public Health | GA00002872 |
| AFY2019 Senate Appropriations Subcommittee - Final With Notes | GA00002873 |
| 02.11.2019_AFY2019 Senate Appropriations Subcommittee - Final With Notes | GA00002874 |
| Email chain from Garry McGiboney to Judy Fitzgerald | GA00003148 |
| email from Ruth Rogers to Judy Fitzgerald re budget meeting FY20 | GA00003149 |
| FY2020 House Appropriations Subcommittee - Draft 1 Powerpoint | GA00003150, GA00003157 |
| email from Christopher Hamilton to Jeffrey Minor re draft budget presentation for the house appropriations subcommittee | GA00003156 |
| email from Nikki Raymond to Kathy Cox re SBMH Statistics | GA00003451 |
| SBMH Statistics | GA00003452 |
| BHPAC Office of Federal Grant Programs 3.12.19 | GA00003632 |
| BHPAC Office of Children Young Adults and Families 3.12.19 | GA00003635 |
| email from Kate Dowd to Judy Fitzgerald et al re SBBH Leadership Committee Meeting | GA00003829 |
| Meeting February 28 2019 minutes | GA00003877 |
| email from Melissa Sperbeck to Judy Fitzgerald re 1115 waiver sampling | GA00004164 |
| 1115 MH and SUD Waiver Sampling 4.2019 | GA00004165 |
| 1115 MH or SUD Waiver Sampling 4.2019 | GA00004168 |
| email from David Sofferin to Judy Fitzgerald re commissioner's corner | GA00004332 |
| BHPAC Office of Children Young Adults and Families 5.14.19 | GA00004376 |
| BHPAC Office of Federal Grant Programs 5.14.19 | GA00004379 |
| MHBG_FY20 CYFMH_PROPOSED SPEND PLAN | GA00004387 |
| Proposed Revised Vision Statement | GA00004388 |
| email from Judy Fitzgerald to Dante McKay re Apex question | GA00004461, GA00004463 |
| Mental Health Month Op-Ed - Draft | GA00004466 |
| DBHDD OCYF Array | GA00004651 |
| Cost Proposal Score Summary - Matt Carter 08242020 | GA00005432 |
| FY19 APEX Deliverables | GA00006702 |
| email from Judy Fitzgerald to Shelli Keller re GAP budget request | GA00006880 |
| FY'19 APEX Contract Budget Expenditure Report-LMCS | GA00006883 |
| Apex May 2018 FY18 (1-2018 to 6-2018) for LMCS | GA00006884 |
| APEX FY'19 Grant Budget Proposal for LMCS | GA00006953 |
| RE_ STATEMENT OF NEED FOR GEORGIA APEX PROGRAM | GA00006954 |
| SAP Presentation May 2 Powerpoint | GA00008363 |
| RE_ Apex related question | GA00031380 |
| email from Dante McKay to Judy Fitzgerald re Apex urgent request | GA00031477 |
| Apex 3.0 Frequently Asked Questions | GA00034767 |
| Commissioner Fitzgerald or Dante Questions | GA00035833 |
| IDT Meeting Notes - 06.15.16 | GA00037283 |
| email from Justin Hill to Debbie Gay re Thomson High School | GA00037326 |
| GaDoe Project Aware Grant powerpoint | GA00037349, GA00037432 |
| NOA R July 2016 | GA00037428 |
| Discipline Data 2014-2015 Excel Spreadsheet | GA00037433 |
| Star Ratings Excel Spreadsheet | GA00037434 |
| FY17 SAMHSA Project AWARE Board Item (003) | GA00037435 |
| Powerpoint SPDG FY16Kimdata | GA00037519 |
| email from Miriam Gudenrath to Rob Rhodes re Georgia Appleseed Tool Kit | GA00037755 |

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| School Data Profile FY16 | GA00037757 |
| ESS Results 2015-16 | GA00038279 |
| GA Beck Initiative Report May 2016 | GA00039866 |
| DBHDD Division of BH PowerPoint Presentation | GA00039933 |
| 2019 BH Symposium Awards | GA00040349 |
| SOC Pocket Guide Terms | GA00043843 |
| Budget Tracking Summary, Updated 7.10.2020 | GA00051873 |
| email from Travis Fretwell to Monica Johnson re Mental Health data on Georgia's 6th-12th graders | GA00055576 |
| Booklet - Families_5-1-19b | GA00070492 |
| CFA Budget Comparison Year Spreadsheet | GA00117567 |
| 2019 BH Symposium - Award Nominations | GA00125537 |
| email from Danielle Jones to Lisa S re office hours recap | GA00128813 |
| email from Danielle Jones to Rachel Campos re evidence based practices | GA00128860 |
| RE_ Apex_ Evaluation Advisory Group | GA00128874 |
| Follow up from All CYF Consortium | GA00129218 |
| email from Danielle Jones to Layla Fitzgerald re APEX | GA00129412 |
| email from Danielle Jones to Dante McKay re MHTTC Info | GA00129622 |
| Apex SON Combined Scoring Matrix_2nd Rd_DM_LF wReasons | GA00140806 |
| SOC Coordinator Roles General Overview | GA00146442 |
| Avita Apex 1.0 May | GA00147138 |
| Apex Monthly Progress Report (MPR) Y6_DRAFT | GA00149352 |
| APEX July Invoice 2.0 | GA00149396 |
| S. GA.Legacy Jul 20 APEX 1.0 - LF | GA00150241 |
| Cobb APEX 1.0 Jul 20 -LF | GA00150245 |
| Cobb_EMERGENCY COVID-19 GRANT PROPOSAL | GA00150919 |
| Legacy BHS APEX Staffing 09.16.2020 | GA00151121 |
| message to Christie Brooksher and others re Apex programmatic report | GA00151392 |
| 2020 Apex Programmatic Report | GA00151394 |
| 2020 Apex Programmatic Report - Updated | GA00151401, GA00219008 |
| Aspire BHDD Budget Letter | GA00191542 |
| Legacy BHS Contract Notification Letter | GA00191587 |
| Apex Providers_Schools_WORKING DRAFT 2.2.16.xlsx | GA00196862 |
| GA Apex 3.0 Budget Aspire | GA00225765 |
| spreadsheet with 2016 student, school year, GNETS fiscal agent data_CONFIDENTIAL INFORMATION – SUBJECT TO PROTECTIVE ORDER.XLSX | GA00000001 |
| spreadsheet with 2017 student, school year, GNETS fiscal agent data_CONFIDENTIAL INFORMATION – SUBJECT TO PROTECTIVE ORDER.XLSX | GA00000002 |
| spreadsheet with 2018 student, school year, GNETS fiscal agent data_CONFIDENTIAL INFORMATION – SUBJECT TO PROTECTIVE ORDER.XLSX | GA00000003 |
| spreadsheet with 2019 student, school year, GNETS fiscal agent data_CONFIDENTIAL INFORMATION – SUBJECT TO PROTECTIVE ORDER.XLSX | GA00000004 |
| spreadsheet with 2016 SY, school info data | GA00000009 |
| spreadsheet with 2017 SY, school info data | GA00000012 |
| spreadsheet with 2018 SY, school info data | GA00000013, GA00000014 |
| spreadsheet with 2019 SY, school info data | GA00000015, GA00000016 |
| spreadsheet with 2020 SY, school info data | GA00000017, GA00000018 |
| Aspire BHDD GA Apex 2.0 Proposed Staffing and School List FY21 Template 04 01 2020 | GA00249577 |
| FY20 Aspire GA APEX Expansion Partially Executed | GA00250912 |
| Apex External Evaluation Survey 02.18.20 | GA00258888 |
| 2020 Apex Programmatic Report - Aspire November 2020 | GA00262121 |
| November 2020 Apex Programmatic Report | GA00262616 |
| GNETS Strategic Plan self assessment-CGCA FY 2020-2021 | R0000160 |
| email from Sandra DeMuth to Jason Byars re copy of home | GA00298913 |
| email from Tammi Clarke to Sandra DeMuth re FY 20 training | GA00302987 |
| email from Sandra DeMuth to Jtammie Clarke re Jot Form Final Sign off 8-21-19 | GA00303767 |
| email from Jason Byars to Tamara Etterling re PBIS involvement | GA00304824 |
| email from Jason Byars to Lara Sims re Tier 2 | GA00305518 |
| email from Garry McGiboney to Jason Byars re PBIS meeting | GA00305793 |
| Jason Byars Deposition Ex 677 | GA00307145 |
| email from Tammi Clarke to Jason Byars re draft FY21 criteria & GNETS question for Jason | GA00308757 |
| email from Justin Hill to Jason Byars re ISF training dates | GA01045886 |

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| Training for Providers by Organization and Type.xlsx | GA01183995 |
| Copy of Book1- POC for CSBMG Apex 1.0 Region 1 and 2 and Apex 2.0 Region 2.xlsx | GA01476434, GA03190829 |
| CSBMG - POC for Apex 1.0 Region 1 and 2 and Apex 2.0 Region 2.xlsx | GA01477391, GA01484763, GA03203809 |
| May 2020 Programmatic Report | GA01482745 |
| Cumulative MPR File Year 5 of the Georgia APEX Program (July 2019-2020) | GA01482780 |
| DBHDD_Data_Warehouse_Extract_-_2019-04-24 DRAFT.xlsx | GA01909424 |
| MidPoint_Data_03.15.2017.csv | GA03888751 |
| year 2 midpoint wide.csv | GA03890317 |
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| May MPR 2020 | GA01482779 |
| June MPR 2021 | GA05559728 |
| APR-FY21-R2 (MG000273-MG000312) | R0020589 |
| FY 21 Apex Contracts-Cover (MG00088-MG000180) | R0020817 |
| FY 22 Apex Contracts (MG000181-MG000269) | R0020911 |
| MPR-02-08-20-R5 - CSBMG (MG002898-MG003341) | R0021444 |
| MPR-05-11-20-R2 - CSBMG Ogeechee Division (MG001109-MG001372) | R0023609 |
| MPR-05-11-20-R5 (MG004442-MG004889) | R0023873 |
| MPR-10-04-21-R2 9 MG001708-MG002078) | R0025805 |
| Strategic Plan FY20-22 | R0026568 |
| Training Apex FY21-FY22 | R0026590 |
| APEX Data YTD FY 20 | R0026733 |
| APEX Programmatic Report 01.20 | R0026828 |
| APEX Programmatic Report 02.20 | R0026830 |
| APEX Programmatic Report 04.20 | R0026832 |
| APEX Programmatic Report 05.20 | R0026835 |
| Apex Programmatic Report 06.20 | R0026839 |
| Apex Programmatic Report 07.20 | R0026845 |
| APEX Programmatic Report 08.20 | R0026848 |
| Apex Programmatic Report 09.20x | R0026851 |
| APEX programmatic report 10 19 | R0026853 |
| Apex Programmatic Report 10.20x | R0026855 |
| Apex Programmatic Report 10.20 | R0026858 |
| APEX programmatic report 7 19 | R0026861 |
| APEX Programmatic Report 8 19 | R0026863 |
| April 2022_Apex Programmatic Report | R0026889 |
| August 2021_Apex Programmatic Report | R0026892 |
| December 2021_Apex Programmatic Report | R0026918 |
| February 2022_Apex Programmatic Report | R0026924 |
| January 2022_Apex Programmatic Report | R0026991 |
| July 2021_Apex Programmatic Report | R0027005 |
| May 2022_Apex Programmatic Report | R0027009 |
| November 2021_Apex Programmatic Report | R0027130 |
| October 2021_Apex Programmatic Report | R0027133 |
| September 2021_Apex Programmatic Report | R0027260 |
| FY21 GA APEX Expansion 2.0 View Point _05_11_21 | VPH000005.002 |
| FY22 View Point GAP 2.0 _05.20.22 | VPH000005.008 |
| View Point Health FY 2023 Georgia Apex Project (GAP) 44100-026-CMA0000317 | VPH000005.022 |
| ViewPoint FY22 GAP 3 #1 | VPH000005.053 |
| VPH FY21 GA Apex Project 1.0 (GAP) - 081820 | VPH000005.067 |
| VPH FY21 GA Apex Project 3.0 (GAP) - 01222021 | VPH000005.097 |
| VPH_APEX 2.0 Invoices_FY21 | VPH000005.127 |
| VPH_Georgia Apex_07.01.20 - 06.30.21 | VPH000005.139 |
| VPH_Georgia APEX_07.01.21 - 06.30.222 | VPH000005.163 |
| Apr 2021_Apex Programmatic Report - Updated. VPH 1_0 | VPH000006.9942 |
| June 2021_Apex Programmatic Report - Updated. VPH 1_0 | VPH000006.9966 |
| Dec 2020_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.9998 |
| Feb 2021_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10002 |
| Jan 2021_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10006 |
| July 2020_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10010 |
| June 2021_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10014 |

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| Mar 2021_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10018 |
| May 2020_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10022 |
| Nov 2020_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10026 |
| Oct 2020_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10030 |
| Sept 2020_Apex Programmatic Report - Updated. VPH 2.0 | VPH000006.10034 |
| Apex Programmatic Report 1.0 21 Dec | VPH000006.10038 |
| Apex Programmatic Report 1.0 21 Nov | VPH000006.10042 |
| Apex Programmatic Report 1.0 21 Oct | VPH000006.10046 |
| Apex Programmatic Report 1.0 21 Sept | VPH000006.10050 |
| Apex Programmatic Report 1.0 22 Apr | VPH000006.10054 |
| year end 2020-2021 VPH | VPH000006.10149 |
| YEAR END VPH 2022 | VPH000006.10159 |
| YEAR END VPH ATL 2022 | VPH000006.10166 |
| VPH Assessments Screenings Billables -Y6 AND Y7 | VPH000008.003, VPH000012.002 |
| Protocols_tools for monitoring social-behavioral-emotional functioning and progress | VPH000013.002 |
| VPH Aggregate Data - Outcomes Tools.xlsx | VPH000014.004 |
| 7 - youth and young adult quarterly July-Sept 2019 Programmatic (ASPIRE001478-ASPIRE001487) | R0078080 |
| 13 - youth and young adult quarterly Oct-Dec 2019 Programmatic (ASPIRE001568-ASPIRE001577) | R0078090 |
| APEX Programmatic Report April 2021 (1) (ASPIRE001578) | R0078171 |
| Aug 2020 Programmatic Report (ASPIRE001592-ASPIRE001594) | R0078175 |
| APEX Programmatic Report Feb 2021 (1) (ASPIRE001802-ASPIRE001804) | R0078181 |
| LCES Feb 2021 error name w LPES (ASPIRE001865-ASPIRE001879) | R0078187 |
| 2020_Apex Programmatic Report - Aspire Jan 2021 (ASPIRE002045-ASPIRE002047) | R0078202 |
| Apex Narrative- July 2020 (ASPIRE002280-ASPIRE002299).odt | R0078208 |
| AMS Sept 2020Apex Reports (ASPIRE003061-ASPIRE003077) | R0078277 |
| Apex Narrative- September 2020 (ASPIRE003078-ASPIRE003097) | R0078295 |
| ECAS Sept 2020 Apex Report (ASPIRE003098-ASPIRE003114) | R0078315 |
| ECES Sept 2020 Apex Report (ASPIRE003115-ASPIRE003131) | R0078332 |
| ECHS Sept 2020 Apex Report (ASPIRE003132-ASPIRE003148) | R0078349 |
| ECMS Sept 2020 Apex Report (ASPIRE003149-ASPIRE003165) | R0078366 |
| KPS Sept 2020 Apex Report (ASPIRE003166-ASPIRE003182) | R0078383 |
| LCME Sept 2020 Apex Report (ASPIRE003183-ASPIRE003199) | R0078400 |
| LCMW Sept 2020 Apex Report (ASPIRE003200-ASPIRE003216) | R0078417 |
| RHH Sept 2020 Apex Report (ASPIRE003217-ASPIRE003233) | R0078434 |
| TLC Sept 2020 Apex Report (ASPIRE003234-ASPIRE003250) | R0078451 |
| WCES Sept 2020 Apex Reports (ASPIRE003251-ASPIRE003267) | R0078468 |
| WCPS Sept 2020 Apex Report (ASPIRE003302-ASPIRE003318) | R0078485 |
| Policy 930 - Nonviolent Practices - Seclusion and Restraint (ASPIRE008666-ASPIRE008680) | R0078812 |
| Albany Area CSB GA APEX Contract (ASPIRE008454-ASPIRE008479) | R0078827 |
| Albany FY21 GAP 3.0 160088 (ASPIRE008481) | R0078883 |
| Apex 1.0 Executed (ASPIRE008482-ASPIRE008509) | R0078914 |
| FY 2023 Georgia Apex 1 Project (GAP) 44100-026-0000166345 (ASPIRE008510) | R0078942 |
| Email from Judy Fitzgerald "The Child Mental Health Gap" | GA00004085 |
| DBHDD Direct Report Organizational Structure | GEORGIA000009 |
| Layla Fitzgerald Deposition Exhibit 182 | GA03130008 |
| Aspire APEX School Wide Data 2016-2017.xlsx | GA03130011 |
| Y3 SBMH Survey Results 5.27.20 | GA04307352 |
| New Provider Orientation (BH) - September 2016.pptx | GA00173838 |
| FY18 Contracts_Provider Utilization 8.1.17.xlsx | GA00182219 |
| Apex Utilization as of 050120.xlsx | GA00224099 |
| May 1.0 Schools and Systems | GA01482783 |
| May 2.0 School and Systems | GA01482794 |
| APR-FY22-R2 | R0020685 |
| All CYF Consortium PowerPoint 8.21.20 | R0026608 |
| Conyers May 2021 | VPH000006.092 |
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| _6 Avita Progress Monitoring Relating to ServicesOutcomes | R0020496 |
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| Viewpoint Health Apex 2.0 Budget and Invoice Template FY22_Jun_2022 ver 2 | VPH000005.191, VPH000005.192 |
| ViewPoint Health 3.0 MAY_2022 | VPH000005.211 |
| year end 2020-2021 ATL | VPH000006.10139 |

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| Berkmar | VPH000006.9681 |
| 2019 BH Symposium - CFP Submittals for Review including workshops not selected for Vets Conf and SOCA.xlsx | GA01459666 |
| Copy of provider reval past due 2019 plus additional info.xlsx | GA02218242 |
| Jason Byars Deposition Ex 672 | GA00303633 |
| Jason Byars Deposition Ex 680 | GA00305809 |
| Jason Byars Deposition Ex 683 | GA00301609 |
| Jason Byars Deposition Ex 691 | GA00298789 |
| Jason Byars Deposition Ex 692 | GA00309926 |
| Jason Byars Deposition Ex 693 | GA00311700 |
| Cheryl Benefield Excel Registration log | GA04476813 |
| DeKalb Response 6072-6114 | R0088081 |
| MPR-01-07-20-R5 | R0021000 |
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| Strategic Plan FY20-22 Review | R0026554 |
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| DOJ Overview Exec Leadership Org Charts | R0020807 |
| GA00000005_CONFIDENTIAL INFORMATION – SUBJECT TO PROTECTIVE ORDER.XLSX | GA00000005 |
| Certificate Level Code Table | GA00000006 |
| Program Codes | GA00000007 |
| Program Codes with Program Name | GA00000008 |
| School Year, System ID, System Name | GA00000010 |
| School Year, System ID, System Name, FAC SCH Type, Grade Range | GA00000011 |
| Apex Narrative- September 2019 (ASPIRE001200-ASPIRE001218) | R0078100 |
| C&A CANS Children (ASPIRE008681) | R0079211 |
| Progress Note and MSE (ASPIRE008684) | R0079246 |
| C&A CANS Core (ASPIRE008682) | R0079213 |
| Activity sheet APEX (ASPIRE008613-ASPIRE008615) | R0079074 |
| APEX STAFF CREDENTIALS (ASPIRE008616).xlsx | R0079077 |
| 10 - youth and young adult Quarterly Comparison Jul 2020-Sept 2020 Programmatic (ASPIRE003472-ASPIRE003481) | R0078138 |
| 2020_Apex Programmatic Report - Aspire JAN 2021 (ASPIRE001801) | R0078178 |
| Apex Narrative- July 2020 (ASPIRE002280-ASPIRE002299) | R0078209 |
| APEX Programmatic Report June 2021 (ASPIRE002512-ASPIRE002515) | R0078245 |
| APEX Programmatic Report March 2021 (ASPIRE002607-ASPIRE002610) | R0078253 |
| APEX Programmatic Report May 2021 (ASPIRE002611-ASPIRE002614) | R0078257 |
| 12 - youth and young adult quarterly Jan-Mar 2020 Programmatic (ASPIRE003494-ASPIRE003504) | R0078160 |
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| GA BNF revised 08.15.18 | GA02488876 |
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| 2010 GNETS Audit | |
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| APEX year end survey 2019-2020 | GA00655695 |
| Apex Y4 Full Annual Evaluation Results (to Bob Putnam) | |
| APEX-PBIS Guide State of Georgia | |
| Aspire 001200 and R 0078119 Aspire Conract Programmatic Report September 2019 | |
| FY14 Operations Manual | |
| GA Apex August 2019 Schools and Districts | |
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| GNETS Rule-20160-4-7-.15[1] (2017) | |
| APEX Abbreviations | |
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| Georgia Governor's Office of Student Achievement Data Report Card | |
| Statewide School Information, Georgia Department of Education, Office of Technology Services | |
| State of Georgia Information, Georgia Department of Education Archives | |

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| "Find a Community Service Board" Georgia DBHDD Website | |
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| Active Provider Directories, Georgia DCH | |
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| EXTERNAL RE GNETS data clarification.msg | |
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| Attachment O_ROG 18 Apex Schools List_2019-2020_May_2.0 | |
| Attachment N_ROG 18 Apex Schools List_2019-2020_May | |
| Apex Program 2021-2022 Evaluation Findings, Georgia Health Policy Center | |
| COE GA Apex Program Annual Evaluation Results Year 4 | GA00000275 |
| Y6 Apex Eval Results | GA05559730 |
| Apex 1.0 Schools_July 2020 | |
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| Apex 3.0 Schools_July 2021 | |
| Apex 2.0 Schools_May 2022 | |
| Apex 2.0 Schools_July 2020 | |
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| Apex 1.0 Schools_May 2022 | |
| Apex 3.0 Schools_May 2022 | |
| Merry Acres 2017-2018 Comprehensive Needs Assessment Report | GA00428282 |
| Aspire APEX Contract Programmatic Report Sep 2020 | |
| GNETS Medicaid Enrollment Status | GA00265967 |
| spreadsheet re program type codes/race/sped area | GA05242021 |
| GNETS programs and codes | GA05242022 |
| SY21 System ID and name codes with type and grade | GA05242430 |
| SY21 System ID and name codes | GA05242082 |
| SY22 System ID and name codes with type and grade | GA05242429 |
| SY22 System ID and name codes | GA05242431 |
| 2022-04-29 Dimple Desai Deposition Transcript Full Print | |
| Fitzgerald.Layla deposition | |
| Fitzgerald.Judith A. Deposition | |
| Georgia Community Service Board Coverage by County | |
| Oosterveen.Lisa Deposition | |
| Hill.Justin 30b6 Deposition | |
| McKay.Dante Deposition | |
| Request for GNETS consultation_ Exhibit 851 | NorthStar_TEMP_000273 |
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| August MPR 2019 | GA01478725 |
| September MPR 2019.xlsx | GA01479427 |
| October MPR 2019.xlsx | GA01479513 |
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| January MPR 2020 | GA01480290 |
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| March MPR 2020.xlsx | GA01481148 |
| April MPR 2020.xlsx | GA01481561 |
| June MPR 2020.xlsx | GA01483474 |
| July MPR 2019 | GA01477802 |
| Apex 1.0 Schools – various months | |
| Apex 2.0 Schools and Systems Report May 2020 | |
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| DBHDD Provider Manual for Community Behavioral Health Providers, FY2016 Quarter 4 through FY2023 Quarter 4 | |
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# APPENDIX C
# SITE VISIT INFORMATION

PART ONE: SITE VISIT LIST
PART TWO: SITE VISIT SUBPOENA

# PART ONE: SITE VISIT LIST

| No. | Affiliated CSB | Site for visit | School district | GNETS program | Site address | Date of visit(s) | PBIS* | Apex** |
|---|---|---|---|---|---|---|---|---|
| 1 | Lookout Mountain | Chattooga High School | Chattooga County | Northwest GA | 989 Hwy 114, Summerville, GA 30747 | 5/9/2022 | n/a as of 2021-22 | n/a as of 2022 |
| 2 | Highland Rivers Health | Coosa High School | Floyd County | Northwest GA | 4454 Alabama Hwy, Rome, GA 30165 | 5/9/2022 | Emerging as of 2021-22 | n/a as of 2022 |
| 3 | Advantage Behavioral | Main Elementary School | Rome City | Northwest GA | 3 Watters St, Rome, GA 30161 | 5/9/2022 | Emerging as of 2021-22 | n/a as of 2022 |
| 4 | Highland Rivers Health | Coosa Middle School | Floyd County | Northwest GA | 212 Eagle Dr NW, Rome, GA 30165 | 5/9/2022 | Operational as of 2021-22 | participating as of 2022 |
| 5 | Lookout Mountain | LeRoy Massey Elementary School | Chattooga County | Northwest GA | 403 Dot Johnson Dr, Summerville, GA 30747 | 5/9/2022 | n/a as of 2021-22 | n/a as of 2022 |
| 6 | Fulton County | Haynes Bridge Middle School | Fulton County | North Metro | 10665 Haynes Bridge Rd, Alpharetta, GA 30022 | 5/10/2022 | Emerging as of 2021-22 | n/a as of 2022 |
| 7 | Fulton County | Centennial High School | Fulton County | North Metro | 9310 Scott Rd, Roswell, GA 30076 | 5/10/2022 | Emerging as of 2021-22 | n/a as of 2022 |
| 8 | View Point Health | North Metro Center (Buice) | Gwinnett County | North Metro | 1225 Northbrook Pkwy, Suwanee, GA 30024 | 5/10/2022 | n/a as of 2021-22 | n/a as of 2022 |
| 9 | View Point Health | Winn Holt Elementary School | Gwinnett County | North Metro | 588 Old Snellville Hwy, Lawrenceville, GA 30046 | 11/14/2022 | Operational as of 2021-22 | n/a as of 2022 |
| 10 | View Point Health | Oakland Meadow School | Gwinnett County | North Metro | 590 Old Snellville Hwy, Lawrenceville, GA 30046 | 11/14/2022 | n/a as of 2021-22 | n/a as of 2022 |
| 11 | View Point Health | Conyers Middle School | Rockdale County | DeKalb-Rockdale | 400 Sigman Rd NW, Conyers, GA 30012 | 11/15/2022 | Emerging as of 2021-22 | participating as of 2022 |
| 12 | View Point Health | Newton High School | Newton County | Mainstay Academy | 1 Ram Way, Covington, GA 30014 | 11/16/2022 | Operational as of 2021-22 | participating as of 2022 |
| 13 | Middle Georgia | Screven County High School | Screven County | Riverquest | 110 Halcyondale Rd, Sylvania, GA 30467-2317 | 12/5/2022 | Emerging as of 2021-22 | participating as of 2022 |
| 14 | Middle Georgia | Montgomery County Middle School | Montgomery County | Heartland | 100 Faye D Brewer St, Mount Vernon, GA 30445 | 12/6/2022 | n/a as of 2021-22 | n/a as of 2022 |
| 15 | Middle Georgia | East Laurens Elementary School | Laurens County | Heartland | 960 US Hwy 80 E, East Dublin, GA 31027-1480 | 12/6/2022 | Emerging as of 2021-22 | participating as of 2022 |
| 16 | DeKalb | Eldridge L. Miller Elementary School | DeKalb County | DeKalb-Rockdale | 919 Martin Rd, Stone Mountain, GA 30088 | 1/18/2023 | Operational as of 2021-22 | n/a as of 2022 |
| 17 | DeKalb | Chamblee High School | DeKalb County | DeKalb-Rockdale | 3688 Chamblee-Dunwoody Rd, Chamblee, GA 30341 | 1/18/2023 | n/a as of 2021-22 | n/a as of 2022 |

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|---|---|---|---|---|---|---|---|---|
| 18 | DeKalb | McLendon Elementary School | DeKalb County | DeKalb-Rockdale | 3169 Hollywood Dr, Decatur, GA 30033 | 1/19/2023 | n/a as of 2021-22 | n/a as of 2022 |
| 19 | DeKalb | Henderson Middle School | DeKalb County | DeKalb-Rockdale | 2830 Henderson Mill Rd, Atlanta, GA 30341 | 1/19/2023 | Emerging as of 2021-22 | participating as of 2022 |
| 20 | DeKalb | Lithonia High School | DeKalb County | DeKalb-Rockdale | 2440 Phillips Rd, Lithonia, GA 30058 | 1/20/2023 | n/a as of 2021-22 | n/a as of 2022 |
| 21 | DeKalb | Salem Middle School | DeKalb County | DeKalb-Rockdale | 5333 Salem Rd, Lithonia, GA 30038 | 1/20/2023 | Operational as of 2021-22 | n/a as of 2022 |
| 22 | Aspire | Early County Elementary School | Early County | Oak Tree | 283 Martin Luther King Jr Blvd, Blakely, GA 39823 | 2/27/2023 | Operational as of 2021-22 | participating as of 2022 |
| 23 | Aspire | Early County High School | Early County | Oak Tree | 12020 Columbia St, Blakely, GA 39823 | 2/27/2023 | Installing as of 2021-22 | participating as of 2022 |
| 24 | Aspire | Terrell County High School | Terrell County | Oak Tree | 201 Greenwave Blvd, Dawson, GA 39842 | 2/28/2023 | Emerging as of 2021-22 | n/a as of 2022 |
| 25 | Aspire | Cooper Carver Elementary School | Terrell County | Oak Tree | 455 Greenwave Dr, Dawson, GA 39842 | 2/28/2023 | Emerging as of 2021-22 | limited Apex participation |
| 26 | Aspire | Lee County Middle School East | Lee County | Oak Tree | 185 Firetower Rd, Leesburg, GA 31763 | 3/1/2023 | Emerging as of 2021-22 | participating as of 2022 |
| 27 | Aspire | Merry Acres Middle School | Dougherty County | Oak Tree | 1601 Florence Dr, Albany, GA 31707 | 3/2/2023 | Installing as of 2021-22 | participating as of 2022 |

*PBIS information compiled from GaDOE's website, which lists Georgia's PBIS LEAs and Schools: https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Pages/Positive-Behavioral-Interventions-and-Support.aspx

**Apex information compiled from site visit interviews and lists of participating schools in Apex 1.0, 2.0, 3.0 produced in response to Plaintiff's First Set of Interrogatories, Interrogatory 18(c) and (d); Plaintiff's First Request for Production of Documents, Request No. 45; and Plaintiff's Third Request for Production of Documents, Request No. 5(d).

# PART TWO: SITE VISIT SUBPOENA

# UNITED STATES DISTRICT COURT

for the

Northern District of Georgia

UNITED STATES OF AMERICA

*Plaintiff*

v.

STATE OF GEORGIA

*Defendant*

Civil Action No. 1:16-CV-03088-ELR

## SUBPOENA TO PRODUCE DOCUMENTS, INFORMATION, OR OBJECTS OR TO PERMIT INSPECTION OF PREMISES IN A CIVIL ACTION

To: DR. JENNIFER BROWN, Superintendent, Early County School System
11927 Columbia Street, Blakely, Georgia 39823

*(Name of person to whom this subpoena is directed)*

*Production:* **YOU ARE COMMANDED** to produce at the time, date, and place set forth below the following documents, electronically stored information, or objects, and to permit inspection, copying, testing, or sampling of the material:

| Place: | Date and Time: |
|---|---|
| | |

✔ *Inspection of Premises:* **YOU ARE COMMANDED** to permit entry onto the designated premises, land, or other property possessed or controlled by you at the time, date, and location set forth below, so that the requesting partymay inspect, measure, survey, photograph, test, or sample the property or any designated object or operation on it as set forth in Attachment A hereto.

| Place: | Date and Time: |
|---|---|
| Early County Elementary School<br>283 Martin Luther King Blvd.<br>Blakely, Georgia 39823 | 02/28/2023 8:00am – 4:00pm<br>(not to exceed 3.5 hours/day) |

The following provisions of Fed. R. Civ. P. 45 are attached – Rule 45(c), relating to the place of compliance; Rule 45(d), relating to your protection as a person subject to a subpoena; and Rule 45(e) and (g), relating to your duty to respond to this subpoena and the potential consequences of not doing so.

Date: 02/14/2023

*CLERK OF COURT*

OR Aileen Bell Hughes

*Signature of Clerk or Deputy Clerk* *Attorney's signature*

The name, address, e-mail address, and telephone number of the attorney representing *(name of party)* the United States of America, who issues or requests this subpoena, are:

Aileen Bell Hughes, 75 Ted Turner Dr. SW, Suite 600, Atlanta, GA 30303; aileen.bell.hughes@usdoj.gov; 404-581-6133

**Notice to the person who issues or requests this subpoena**

If this subpoena commands the production of documents, electronically stored information, or tangible things or the inspection of premises before trial, a notice and a copy of the subpoena must be served on each party in this case before it is served on the person to whom it is directed. Fed. R. Civ. P. 45(a)(4).

Civil Action No. 1:16-CV-03088-ELR

**PROOF OF SERVICE**

***(This section should not be filed with the court unless required by Fed. R. Civ. P. 45.)***

I received this subpoena for *(name of individual and title, if any)* _____

on *(date)* _____ .

' I served the subpoena by delivering a copy to the named person as follows: _____

_____

_____ on *(date)* _____ ; or

' I returned the subpoena unexecuted because: _____

_____ .

Unless the subpoena was issued on behalf of the United States, or one of its officers or agents, I have also tendered to the witness the fees for one day's attendance, and the mileage allowed by law, in the amount of $ _____ .

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____ _____

*Server's signature*

_____

*Printed name and title*

_____

*Server's address*

Additional information regarding attempted service, etc.:

Print Save As... Add Attachment Reset

## Federal Rule of Civil Procedure 45 (c), (d), (e), and (g) (Effective 12/1/13)

**(c) Place of Compliance.**

**(1)** ***For a Trial, Hearing, or Deposition.*** A subpoena may command a person to attend a trial, hearing, or deposition only as follows:

**(A)** within 100 miles of where the person resides, is employed, or regularly transacts business in person; or

**(B)** within the state where the person resides, is employed, or regularly transacts business in person, if the person

**(i)** is a party or a party's officer; or

**(ii)** is commanded to attend a trial and would not incur substantial expense.

**(2)** ***For Other Discovery.*** A subpoena may command:

**(A)** production of documents, electronically stored information, or tangible things at a place within 100 miles of where the person resides, is employed, or regularly transacts business in person; and

**(B)** inspection of premises at the premises to be inspected.

**(d) Protecting a Person Subject to a Subpoena; Enforcement.**

**(1)** ***Avoiding Undue Burden or Expense; Sanctions.*** A party or attorney responsible for issuing and serving a subpoena must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena. The court for the district where compliance is required must enforce this duty and impose an appropriate sanction—which may include lost earnings and reasonable attorney's fees—on a party or attorney who fails to comply.

**(2)** ***Command to Produce Materials or Permit Inspection.***

**(A)** *Appearance Not Required.* A person commanded to produce documents, electronically stored information, or tangible things, or to permit the inspection of premises, need not appear in person at the place of production or inspection unless also commanded to appear for a deposition, hearing, or trial.

**(B)** *Objections.* A person commanded to produce documents or tangible things or to permit inspection may serve on the party or attorney designated in the subpoena a written objection to inspecting, copying, testing, or sampling any or all of the materials or to inspecting the premises—or to producing electronically stored information in the form or forms requested. The objection must be served before the earlier of the time specified for compliance or 14 days after the subpoena is served. If an objection is made, the following rules apply:

**(i)** At any time, on notice to the commanded person, the serving party may move the court for the district where compliance is required for an order compelling production or inspection.

**(ii)** These acts may be required only as directed in the order, and the order must protect a person who is neither a party nor a party's officer from significant expense resulting from compliance.

**(3)** ***Quashing or Modifying a Subpoena.***

**(A)** *When Required.* On timely motion, the court for the district where compliance is required must quash or modify a subpoena that:

**(i)** fails to allow a reasonable time to comply;

**(ii)** requires a person to comply beyond the geographical limits specified in Rule 45(c);

**(iii)** requires disclosure of privileged or other protected matter, if no exception or waiver applies; or

**(iv)** subjects a person to undue burden.

**(B)** *When Permitted.* To protect a person subject to or affected by a subpoena, the court for the district where compliance is required may, on motion, quash or modify the subpoena if it requires:

**(i)** disclosing a trade secret or other confidential research, development, or commercial information; or

**(ii)** disclosing an unretained expert's opinion or information that does not describe specific occurrences in dispute and results from the expert's study that was not requested by a party.

**(C)** *Specifying Conditions as an Alternative.* In the circumstances described in Rule 45(d)(3)(B), the court may, instead of quashing or modifying a subpoena, order appearance or production under specified conditions if the serving party:

**(i)** shows a substantial need for the testimony or material that cannot be otherwise met without undue hardship; and

**(ii)** ensures that the subpoenaed person will be reasonably compensated.

**(e) Duties in Responding to a Subpoena.**

**(1)** ***Producing Documents or Electronically Stored Information.*** These procedures apply to producing documents or electronically stored information:

**(A)** *Documents.* A person responding to a subpoena to produce documents must produce them as they are kept in the ordinary course of business or must organize and label them to correspond to the categories in the demand.

**(B)** *Form for Producing Electronically Stored Information Not Specified.* If a subpoena does not specify a form for producing electronically stored information, the person responding must produce it in a form or forms in which it is ordinarily maintained or in a reasonably usable form or forms.

**(C)** *Electronically Stored Information Produced in Only One Form.* The person responding need not produce the same electronically stored information in more than one form.

**(D)** *Inaccessible Electronically Stored Information.* The person responding need not provide discovery of electronically stored information from sources that the person identifies as not reasonably accessible because of undue burden or cost. On motion to compel discovery or for a protective order, the person responding must show that the information is not reasonably accessible because of undue burden or cost. If that showing is made, the court may nonetheless order discovery from such sources if the requesting party shows good cause, considering the limitations of Rule 26(b)(2)(C). The court may specify conditions for the discovery.

**(2)** ***Claiming Privilege or Protection.***

**(A)** *Information Withheld.* A person withholding subpoenaed information under a claim that it is privileged or subject to protection as trial-preparation material must:

**(i)** expressly make the claim; and

**(ii)** describe the nature of the withheld documents, communications, or tangible things in a manner that, without revealing information itself privileged or protected, will enable the parties to assess the claim.

**(B)** *Information Produced.* If information produced in response to a subpoena is subject to a claim of privilege or of protection as trial-preparation material, the person making the claim may notify any party that received the information of the claim and the basis for it. After being notified, a party must promptly return, sequester, or destroy the specified information and any copies it has; must not use or disclose the information until the claim is resolved; must take reasonable steps to retrieve the information if the party disclosed it before being notified; and may promptly present the information under seal to the court for the district where compliance is required for a determination of the claim. The person who produced the information must preserve the information until the claim is resolved.

**(g) Contempt.**

The court for the district where compliance is required—and also, after a motion is transferred, the issuing court—may hold in contempt a person who, having been served, fails without adequate excuse to obey the subpoena or an order related to it.

For access to subpoena materials, see Fed. R. Civ. P. 45(a) Committee Note (2013).

# Attachment A

Pursuant to the terms of the attached subpoena to permit inspection of premises in a civil action, the United States of America, by and through the United States Department of Justice ("DOJ"), intends to inspect the premises identified by address in the attached subpoena on the date specified. This inspection, or "site visit," will be conducted in accordance with the terms set forth below.

*General Health and Safety Precautions*

In order to limit the number of personnel in any given facility at one time, the United States will limit its inspection team to a maximum of two DOJ employees and an expert. DOJ will provide the names of the visiting team members one week in advance of the site visit. All DOJ team members will wear masks (except as may be reasonably necessary to conduct an interview), regardless of whether the underlying facility operates under a mask mandate. Team members will abide by any sign-in policies and procedures regularly applied to visitors to the premises.

The United States requests that a school administrator attend during the entirety of the inspection of the identified premises. In the event a student has a crisis or any other urgent school-based situation arises, the DOJ team will immediately follow the administrator's instructions for responding to the crisis/situation.

By this attachment, the United States requests that other counsel and individuals attending the inspection proceed in similar fashion.

*Expert Site Visit*

The purpose of these site visits is to allow the United States' expert Dr. Robert F. Putnam, PhD., LABA, BCBA-D, an opportunity to obtain information that he needs to form opinions in the matter of *United States v. Georgia*, No. 16 Civ. 3088 (N.D. Ga.). Dr. Putnam specializes in the fields of special education and behavioral psychology. He has extensive experience touring educational facilities, observing classroom instruction, interviewing staff and administration, and assessing student programming and engagement in a manner that minimizes disruption to school operations. Dr. Putnam will tour the school, make observations, and interview school personnel to the extent described below in the "Scope" section of this Attachment A.

*Timing*

The United States will schedule the visit during normal school hours, as necessary to accommodate travel schedules and school personnel. The total length of the inspection shall not exceed 3.5 hours. So long as total inspection time for a single team does not exceed 3.5 hours, the expert's time spent on any particular aspect of the site visit shall not be limited. In advance of the visit, the United States will work with counsel to identify more specific arrival and departure times that do not interrupt the start or dismissal of school.

*Scope of Inspection*

The inspection will include three aspects: a physical inspection, classroom observations, and informal interviews. Within the 3.5-hour overall timeframe, the length of any portion of the inspection shall be determined on site by Dr. Putnam, in his reasonable discretion.

1. Physical Inspection

The physical inspection shall include a tour of such areas of the school facility as may be selected by Dr. Putnam from the following list:

- Any classrooms that serve any student enrolled in any general education or special education;
- Any classrooms that serve any student enrolled in a GNETS program;
- Any classrooms or other areas linked to "specials," "connections," or "electives" (e.g., art, music, theatre, band, career tech);
- Media center/Library;
- Gymnasium;
- Cafeteria;
- Science Labs;
- Computer Labs;
- Playground/Outdoor Athletic Facilities;
- Sensory Rooms and/or De-escalation Rooms;
- Any rooms that are used to provide therapeutic services, whether to students in the GNETS programs or to students with or without disabilities in the general education school;
- Counseling Office/Center;
- Nurse's Office/Station;
- Storage rooms/closets within GNETS school-based classrooms; and
- Any other area of the premises accessed or utilized by students not specifically identified above.

2. Classroom Observation

Dr. Putnam may observe classroom instruction or any other activity taking place in any GNETS, special education, or general education classroom. One DOJ employee shall have the right to enter a classroom to accompany Dr. Putnam while he is conducting his observations. Dr. Putnam and the DOJ employee shall make all reasonable efforts to stand and/or sit in the area of the classroom least likely to cause disruption. In most cases, this area will be the back or side of the classroom.

Dr. Putnam shall have reasonable leeway to adjust his position within the classroom where needed to observe what students are working on and students' level of engagement and classroom instruction. Dr. Putnam shall determine the duration of the classroom visit and, if requested, shall be permitted to return to a classroom already observed for additional observation. Additionally, Dr. Putnam and a DOJ employee shall be permitted to observe—either from a stationary position in a classroom or in a hallway—periods of transition where students move to and from classrooms or other areas of the school facility.

At no time during the observation will Dr. Putnam question or otherwise engage students or classroom personnel beyond exchanging common pleasantries (e.g., responding to a "hello," saying "thank you" or smiling). In the event classroom personnel or students speak to the experts unprompted, the experts will minimize communication by responding with a nod or by saying "thank you" or "okay."

3. Interviews of School Personnel

Dr. Putnam will have the opportunity to interview the following school employees:

a) the school principal;

b) an individual or individuals knowledgeable about: participation in the APEX program, if applicable, and the qualifications required of, caseloads of, and services provided by mental and/or behavioral health staff to students in the school, including by school psychologists, licensed social workers, mental health counselors, Board Certified Behavior Analysts ("BCBAs"), family therapists, and mental health paraprofessionals, and any other staff who regularly provide mental and/or behavioral health services to students at the school;

c) an individual or individuals knowledgeable about: the mental and/or behavioral health needs of students, the procedures for referral of students for mental and/or behavioral health services, any school improvement plan for students with mental and/or behavioral health needs, professional development for mental and/or behavioral health staff, monitoring of fidelity and effectiveness of mental and/or behavioral health services used in the school, and inclusion of students with mental and or behavioral health diagnoses within general education programs and activities in the school;

d) an individual or individuals knowledgeable about: data collected on students at risk of more restrictive placements, GNETS services in the school, problems and behaviors that would result in a GNETS referral, and services provided and initiatives undertaken to avoid referring a student to GNETS;

e) an individual or individuals knowledgeable about: each alternative classroom at the school, including both GNETS and any other alternative classrooms offered to students with mental health diagnoses;

f) an individual or individuals knowledgeable about: school climate, implementation of Positive Behavioral Interventions and Supports, implementation of steps to improve the whole school climate, and behavioral interventions at the school; and

g) an individual or individuals knowledgeable about: discipline at the school.

The United States will work with counsel for the district to identify the specific employees who will be interviewed in advance of the visit.

*Expert and Team Member Documentation*

Dr. Putnam may document the nature, condition, and appearance of the premises via photographs so long as the photographs taken do not include students, parents/guardians, building personnel, or any other images that implicate the Family Educational Rights and Privacy Act. No other limitations shall be placed on Dr. Putnam's right to photograph the premises.

All members of the DOJ team participating in the inspection of the premises, including Dr. Putnam, shall have the right to document any part of the inspection by taking notes. No restrictions shall be placed on this right.

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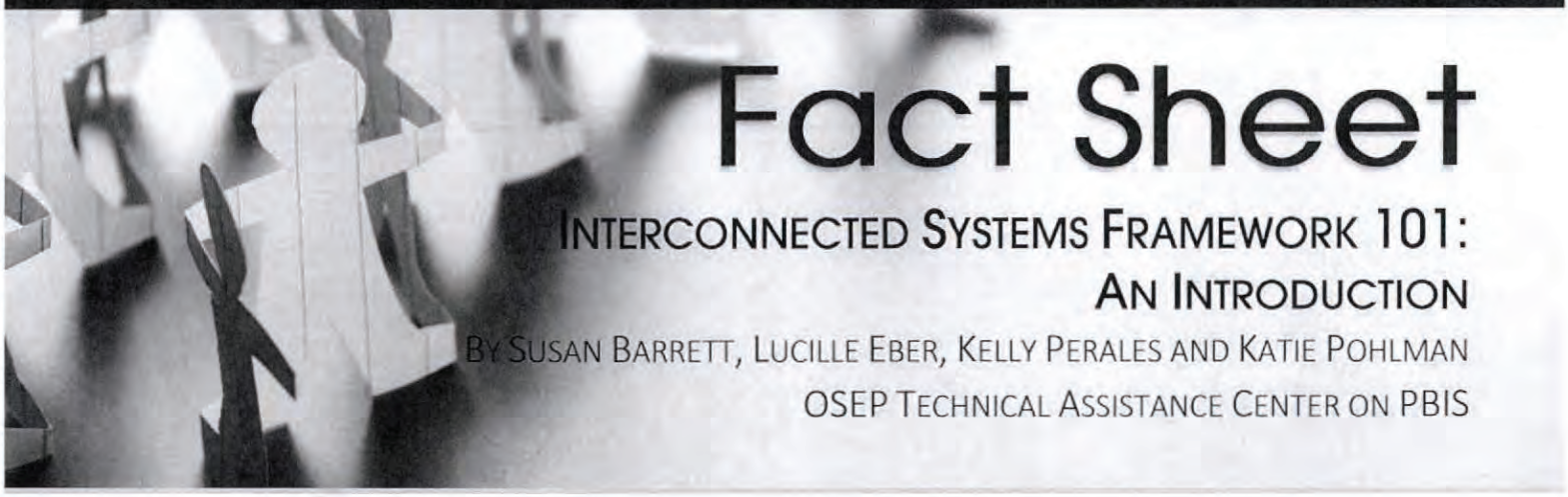

# Fact Sheet

## Interconnected Systems Framework 101: An Introduction

By Susan Barrett, Lucille Eber, Kelly Perales and Katie Pohlman
OSEP Technical Assistance Center on PBIS

In the United States, over 40% of students will have experienced a mental health problem, such as anxiety or depression, by the time they reach seventh grade (SAMHSA, 2016). Suicide is the second leading cause of death among 10-34 year olds (NIMH, 2018) and according to the National Survey of Children's Health (2016), 46% of children have experienced at least one Adverse Childhood Experience (ACE). The newest statistics on suicide from the Centers for Disease Control (CDC), along with current rates of substance use, opioid abuse, and electronic aggression are alarming. This public health crisis requires a whole population response. Education and mental health leaders are keenly aware of the need to align structures and establish one comprehensive system of social/emotional/behavioral (SEB) supports in schools.

The Interconnected System Framework (ISF) is an emerging approach for building a single system of SEB supports in schools. Integrating Positive Behaviorial Interventions and Supports (PBIS) and school mental health, the ISF also brings community partners and families into one multi-tiered structure.

The Pacific Southwest Mental Health Technology Transfer Center (MHTTC), in collaboration with the OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports (PBIS), has developed a three-part series of fact sheets to deepen knowledge and understanding of the ISF. All three documents provide case examples that highlight the local context in which data-based decision making occurs and reflect the diversity of school communities in the region.

- ***Interconnected Systems Framework 101*** provides an introduction to Interconnected Systems Framework, including a definition and a review of the benefits.
- ***Interconnected Systems Framework 201*** describes what will be different for educators and mental health providers when school mental health is integrated into a Multi-Tiered System of Support. (MTSS)
- ***Interconnected Systems Framework 301*** describes how to use school and community data to determine what interventions to select and implement to meet the diverse needs of all students.



PBIS Positive Behavioral Interventions & Supports
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## What is the Interconnected Systems Framework (ISF)?

The ISF is offered as a solution to the inefficiencies of co-located systems and SEB programs working in isolation. Building on the success of PBIS, the ISF applies the core features of MTSS to *deliberately integrate mental health, community, school, and family partners through a single system of support.* The MTSS framework guides state, district, and community leaders to blend funding and modify policies and procedures to help systems work more efficiently. Supported by integrated district structures, clinicians become part of multi-tiered teams in schools where the SEB needs of all students are addressed.

### Key Messages of ISF

1. **Single System of Delivery**
2. **Mental Health is for ALL**
3. **Success Defined by Student Impact**
4. **Use the MTSS framework to guide an integrated approach:**
   - Team-based decision making
   - Use of school and community data
   - Formal process for the selecting evidence-based practices (EBPs) connected across tiers
   - Early access through comprehensive screening
   - Rigorous progress monitoring for fidelity and impact
   - Ongoing coaching for school and community professionals

## The Building Blocks of the Interconnected Systems Framework: PBIS and SMH

PBIS is a multi-tiered behavior system currently implemented in over 26,000 schools. PBIS focuses on building effective systems and structures that can inform a collective approach to data-driven decision making and the implementation of evidence-based practices (EBPs). The primary goal of PBIS is to promote SEB functioning in students (Horner, Sugai, & Anderson, 2010).

While PBIS has improved behavioral and academic outcomes for students for over two decades, schools often struggle to provide adequate support for students displaying higher level needs (Barrett et al., 2013). Furthermore, PBIS has historically focused on overt problem behavior, which can result in missing the needs of students with "internalizing" problems such as anxiety, depression, and the impact of trauma (Weist et al., 2018).

Like PBIS, school mental health has been a decade long national movement to develop mental health services for children and youth to serve them "where they are," (Weist & Ghuman, 2002), resulting in increased school-based mental health services. There are documented advantages of school-based mental health programs, including significantly improving access to services (Atkins et al., 2006; Catron, Harris, & Weiss, 1998); promoting positive student SEB; and fostering better academic outcomes. When programs are implemented appropriately, there are many advantages to school-based mental health programs (Botvin, 2000; Catalano et al., 2003). Like PBIS, however, expanded school-based mental health programs have limitations related to poor implementation support, and are often delivered in an ad-hoc way in school districts. One consequence of this approach is that community mental health clinicians generally do not participate actively on MTSS teams, operating in parallel to PBIS programs rather than in coordination with PBIS (Eber et al., 2013; Splett et al., 2014). Applying the ISF allows schools, districts, and

states to improve their service delivery model by investing in one set of teams to support SEB and academic supports for all.

### Getting Started

The ISF builds on the strengths from student mental health approaches and PBIS to help education and mental health systems work together. Here are some of the initial steps for practitioners who are interested in using this approach:

- Resource Mapping is a good first activity to help district and community leaders start examining what mental health resources are currently available. This process also helps teams discover the extent to which their current SEB initiatives (e.g. Social Emotional Learning, Bully Prevention, Restorative Practices, and Trauma-Informed Care) are implemented with high quality and examine if they are having a positive impact on student outcomes. Finally, the mapping process allows the team to discuss opportunities to align, integrate, and eliminate, where possible, to establish a more efficient and effective system.

### Benefits of ISF

- **Uncovering students with mental health needs earlier**
- **Linking students with needs to evidence-based interventions**
- **Data tracking system to ensure youth receiving interventions are showing improvement**
- **Expanded roles for clinicians to support adults as well as students across all tiers of support.**
- **Healthier school environment**

### Evidence of Impact of PBIS

- **Improved academic achievement** (McIntosh, Chard, Boland, & Horner, 2006)
- **Reduced student discipline referrals and suspensions** (Anderson & Kincaid, 2005; Frey, Lingo, & Nelson, 2008)
- **Improved social emotional functioning** (Kincaid, Knoster, Harrower, Shannon, & Bustamante, 2002, Bradshaw et al., 2012)

- If districts already have a community provider working in schools, leaders should examine how that agency is working alongside school based teams to ensure an integrated approach. This includes reviewing existing working agreements, contracts, and funding structures to consider how the agreements promote or prevent an integrated approach. The following questions can be used to facilitate discussions and revise the working agreements.
  - Are roles and functions clearly defined across the tiers of implementation?
  - How is funding blended to enable providers to serve on teams across tiers?
  - What professional development training and coaching is required to ensure staff are skilled to deliver interventions and clinicians can support teachers in their classrooms?
  - How are community providers invited to participate in district trainings and team meetings and learn about how the education system operates?

## Resource

### Aligning and Integrating Mental Health and PBIS to Build Priority for Wellness

View Resource

The 2017 PBIS Leadership Forum hosted an intensive track on the integration of mental health and PBIS. This resource summarizes the ten presentations and roundtable discussion dialogue and includes a FAQ on ISF. It is organized by discrete, progressive steps that schools can take align their mental health and PBIS systems through the ISF. Case examples from sites currently implementing ISF help illuminate the alignment process.

## Local Spotlight

In California, school districts and behavioral health are using an ISF approach to move from a co-located model to an integrated model. To accomplish this integrated approach, funding for behavioral health services is blended using student Medi-Cal insurance and district allocations from Local Control Accountability Plans (LCAP) and the Individuals with Disabilities Education Act (IDEA) provided through Special Education Local Plan (SELPA). This blended fiscal model allows for integrated services, making clinicians active participants on PBIS teams. Clinicians are assigned to one school and are part of the school community. They facilitate interventions for students requiring intensive supports and also serve on School Wide Leadership team using their expertise as social emotional leaders to train and support instructional staff to teach social emotional skills alongside academic content. This blended fiscal model ensures clinicians build the capacity for ALL staff to respond to the needs for most of the children and youth within the school community without requiring students to have a label, diagnosis, or insurance plan to get supports.

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